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MACRA AND MIPS: AN UPDATE ON THE MERIT-BASED INCENTIVE PAYMENT SYSTEM

THURSDAY, JULY 26, 2018

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Shimkus, Latta, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Hudson, Collins, Carter, Green, Engel, Matsui, Castor, Schrader, Kennedy, Eshoo, and Pallone (ex officio).

Staff present: Mike Bloomquist, Staff Director; Samantha Bopp, Staff Assistant; Adam Buckalew, Professional Staff Member, Health; Daniel Butler, Legislative Clerk, Health; Jordan Davis,

Senior Advisor; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Associate, Health; Ed Kim, Policy Coordinator, Health; Ryan Long, Deputy Staff Director; Drew McDowell, Executive Assistant; James Paluskiewicz, Professional Staff, Health; Brannon Rains, Staff Assistant; Jennifer Sherman, Press Secretary; Josh Trent, Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Senior Health Counsel; and Samantha Satchell, Minority Policy Analyst.

Mr. Burgess. [presiding] The Subcommittee on Health will now come to order.

And I recognize myself for 5 minutes for an opening statement.

Today's hearing is one that has been in the works for quite some time. As many of you know, this hearing has been rescheduled twice. But, given that we have now enacted important technical changes, providers having information on their first performance year, and this year's Quality Payment Program rules to discuss, this hearing is timely now. I am glad we can complete our due diligence, as members of the Health Subcommittee, and conduct oversight and the implementation of the Medicare Access and CHIP Reauthorization Act of 2015.

This bill, which came through the 114th Congress, is a product of careful, intricate bipartisan negotiations and was passed by both chambers of Congress with broad support. Signed into law on April 16, 2015, this bill repealed the sustainable growth rate formula for all time. The sustainable growth rate formula was for calculating annual updates to physician payment rates under Medicare. We now know that the formula, which was enacted as part of the Balanced Budget Act of 1997, turned out to be unwise.

As an OB/GYN prior to coming to Congress, I was frustrated with the annual exercise of the sustainable growth rate formula, as were many other physicians, as were Members of Congress. I

would like to take a moment to remind members of what the world of physician payments looked like before the repeal or before the passage of the Medicare Access and CHIP Reauthorization Act.

Congress consistently passed legislation to override the SGR. That resulted in hundreds of billions of dollars spent that could have gone to bolstering Medicare and other health programs. Medicare providers and their patients by extension were under the constant threat of payment cuts under the sustainable growth rate formula. The formula's unrealistic assumptions of spending and efficiency have plagued the healthcare profession and our Medicare beneficiaries for a long time.

The Medicare Access and CHIP Reauthorization Act repealed the SGR, provided for statutory updates to allow improved beneficiary access, and got medicine to concentrate on moving to broad adoption of a quality reporting system. One of the most important provisions in the law was a shift from a fee schedule system towards a merit-based incentive payment system. The law left behind a pass/fail quality reporting regime whose measures were too often set up against a one-size-fits-all generic standard of care with no financial upside for providers.

Since the merit-based system was set to go into full effect on January 1st, 2019, the first payment consequence year, from reporting provided in 2017, it is critical that we hold this hearing and hear from our witnesses, in a sense, what is working, how the transition is progressing, and where improvements have

been made while seeking ways to simultaneously encourage stronger participation and reward providers already invested in the MIPS track.

The Medicare Access and CHIP Reauthorization Act required the Secretary of Health and Human Services to establish a methodology to assess merit-eligible practitioners and give each one a performance score which determines payments based on a scale of 1 to 100. In the first year, the performance benchmark was set at 3. This year it was set at 15, and the Centers for Medicare and Medicaid Services recently proposed raising it to 30 for 2019.

The merit-based incentive payment system incorporated specific performance categories, including quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records. The eligible population was also set to change over time. And the Centers for Medicare and Medicaid Services recently proposed to add a slate of additional providers to the program.

Overall, stakeholders and physicians have been supportive of the transition. In our third hearing, we heard from providers getting the benefits of savings by participating in the advanced alternative payment model. That said, the Medicare Access and CHIP Reauthorization Act was a long-term project and a viable fee-for-service model in the form of the merit-based incentive payment system needed to exist.

In continuing to follow the Medicare Access and CHIP

Reauthorization Act implementation, certain decisions were made by the Centers for Medicare and Medicaid Services that were for the benefit of a smooth transition, but had consequences, consequences that affected the agency's trajectory of setting the performance threshold. Given this and other developments, I believe that the law would benefit from technical updates to improve the implementation based on real-time factors. The Bipartisan Budget Act of 2018 included three technical fixes. This was done by myself, Ranking Member Green, and Representatives Roskam and Levin from the Ways and Means Committee.

The Medicare Access and CHIP Reauthorization Act changed the world of Medicare provider payments. It has laid the groundwork for increased access to quality care for beneficiaries by eliminating the uncertainty of the past, reducing physician burden, and providing incentives where previously there were none. It was never a law that was going to be fully implemented with the flip of a switch or a signing ceremony. It was designed as a long-term effort to move the Medicare program down the value continuum.

So, once again, I want to thank our witnesses for joining us today. I look forward to hearing from each of you about how the implementation of this important law is progressing.

I yield back the balance of my time and recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening

statement.

Mr. Green. Thank you, Mr. Chairman, for holding today's hearing on the Medicare Access and CHIP Reauthorization, MACRA, and the merit-based incentive payment system, MIPS.

I also thank our esteemed panelists for joining us this morning.

The sustainable growth rate, SGR, was a thorn in the side of Medicare and doctors who treated Medicare patients for over decade after it was created in 1997. SGR's formula led to a reduction of physician payments, starting in 2002, that had to be patched annually by Congress.

In 2014 and 2015, our committee, along with other committees with jurisdiction, came together and passed bipartisan legislation, the Medicare Access and CHIP Reauthorization Act, which permanently repealed the SGR. MACRA did more than just repeal the flawed SGR formula. It was designed to overhaul and realign payment incentives for Medicare and transition of our health system to one that rewards value instead of just the volume of care. MACRA provides civility to Medicare payments for providers for the years immediately after the enactment and made it easier for providers to report on and deliver high-quality care.

Critically, MACRA encourages providers to move away from fee-for-service and participate in a new delivery model that would reduce costs while increasing quality. Under the law, physicians

who treat Medicare beneficiaries have a choice between participating in MIPS or the advanced alternative to payment plan, APMs, to make the shift from fee-for-service and volume-based payment system to a value-based payment system. MIPS streamlined three prior quality incentive programs that were sunset in 2016 and have been replaced by a new MIPS category, quality, improvement activities, meaningful use, and cost.

Since starting in 2017, healthcare providers could choose whether to participate in APM or MIPS. Providers are exempt from MIPS if they fall below the low-volume threshold. For 2017, the Centers for Medicare and Medicaid set the low-volume threshold for providers who see fewer than 100 Medicare Part B patients or have less than $30,000 in Part B charges annually. For 2018, CMS increased the low-volume threshold to $90,000 in Part B charges or fewer than 200 Medicare patients per year. And for the next year, CMS has proposed maintaining the low-volume threshold for MIPS while adding a third exemption route for clinicians providing less than 200 covered services. CMS has proposed allowing clinicians who meet the exemption criteria to opt into MIPS.

Under MACRA, the Department of Health and Human Services is required to set the performance threshold by 2019 at the mean or median of final scores for all MIPS-eligible clinicians. In February, Congress passed legislation changing the timeline to ease the burden of the MIPS transition. The Bipartisan Budget

Act of 2018 granted HHS an additional three years to ensure gradual, incremental transition to the mean or median of performance.

I look forward to hearing from our panelists regarding their experience with MIPS and recent changes made by Congress, whether additional action is necessary to ensure physicians participating in MIPS is generating savings to Medicare and improving patient outcomes.

Thank you, Mr. Chairman. I yield back my time. There is nobody on our side. So, I don't think they want any time.

Mr. Burgess. I thank the gentleman for yielding back. The gentleman does yield back.

There is three minutes left on the vote on the Floor. We are going to recess until immediately after the vote on the Floor.

[Recess.]

Mr. Burgess. I call the committee back to order.

We are still waiting on the return of the ranking member and the chairman of the full committee, but anticipating that they will arrive, let's thank our witnesses for being here today and taking time to testify before the subcommittee.

Each witness is going to have the opportunity to give an opening statement, followed by questions from members. Today we will hear from Dr. David Barbe, the Immediate Past President of the American Medical Association; Dr. Frank Opelka, Medical Director, Quality and Health Policy, American College of

Surgeons; Dr. Ashok Rai, Chairman of the Board, American Medical Group Association; Dr. Parag Parekh, American Society of Cataract and Refractive Surgery, and Kurt Ransohoff, Chairman of the Board, America's Physician Groups.

We appreciate you being here today, Doctors.

And, Dr. Barbe, you are now recognized for 5 minutes to give an opening statement, please.

STATEMENTS OF DR. DAVID BARBE, IMMEDIATE PAST PRESIDENT, AMERICAN MEDICAL ASSOCIATION; DR. FRANK OPELKA, MEDICAL DIRECTOR, QUALITY AND HEALTH POLICY, AMERICAN COLLEGE OF SURGEONS; DR. ASHOK RAI, CHAIRMAN OF THE BOARD, AMERICAN MEDICAL GROUP ASSOCIATION; DR. PARAG PAREKH, AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY, AND DR. KURT RANSOHOFF, CHAIRMAN OF THE BOARD, AMERICA'S PHYSICIAN GROUPS

STATEMENT OF DR. DAVID BARBE

Dr. Barbe. Chairman Burgess, Ranking Member Green, and committee members, thank you very much for the opportunity to come here today and to update you on the continuing implementation of MACRA.

I am a practicing family physician from rural southern Missouri, actually in Congressman Long's neck of the woods, and as you say, Past President of the AMA.

Physicians are familiar with value-based payment mechanisms. We have been subject to those for over 10 years, starting with PQRI, which was the original quality-based program. That was in 2007. Meaningful use came in in 2009. Value-based payments began in 2013. But each of these programs came in at separate times under separate bills, were never harmonized, never even contemplated working together. And all of them started as incentive programs, but most of them have transitioned into penalty programs which are additive.

As of now, a physician who is not able to perform, for whatever reason, in those programs could be subject to up to 11-percent negative adjustment in their Medicare reimbursement. That was simply not sustainable, and we thank you and the others that worked so hard on MACRA in 2015. That is a significant step forward. Not only did it repeal the SGR, as has been noted, but it began to harmonize these programs, bringing them under one administration, if you will, and it also reset, very importantly, the incentive and penalty corridor, such that for performance in the first year of 2017, it was a plus or minus 4 percent, certainly a better opportunity for physicians to succeed under that particular framework. So, we appreciate the work that went into that.

We share a common goal with you in seeing that this program, these new quality payment programs are implemented appropriately, that the transition is smooth. Because we believe that the success of these programs has a real opportunity to improve quality for patients, to bend the cost curve. But, for them to be successful, physicians have to be able to succeed under these programs as well. Again, MACRA took us a significant step toward physician success and improving these programs.

In your opening remarks, you mentioned BBA 2018 and the significant improvements and technical fixes that were made. We really appreciated those as well. We will continue to work closely with you because, as you also suggested, this wasn't a

one-and-done. This is an evolving process. And hearings like this today, allowing us to update you, are critical in continuing to improve that process for patients, physicians, and for the Medicare program.

As a part of the BBA 2018, we strongly support the Part B drug cost exclusion. We support flexibility for CMS to re-weight the cost performance measures. We appreciate the performance threshold flexibility that you gave CMS. We need now for CMS to use the flexibility that you gave them to make this transition appropriate. So, we will continue to work with them. We have made multiple suggestions already, and we will continue to try to make this transition appropriate.

One of the other pretty important parts of what you enabled was for PTAC to consult with physician groups as we develop physician-focused payment models. The PTAC has been doing what you have wanted it to do. They have received dozens of proposals, and they have even recommended about 10 of those onto CMS. Unfortunately, CMS has not seen fit to adopt any of those yet, and I think it is thwarting the creativity and innovation that physicians are willing to bring to the table. So, we will continue to work with CMS to try to get them to consider and adopt some of those alternative payments models that are physician-focused that PTAC has recommended.

And I think, lastly, you may hear some discussion today about the limitation of the upside opportunity to something in the

2-percent range, rather than the 4 percent that was originally contemplated. Again, the goal is to help physicians succeed. All of the organizations represented here represent a wide range of physician practices, physician styles. The AMA certainly does. We represent physicians from all specialties, all practice types.

It is critically important that all those physicians have an opportunity to succeed under this program. Whether you are a large megagroup like the one I am in or whether you are a single, independent physician practicing someplace else in Missouri, you need an opportunity. And so, CMS needs flexibility. We need a smooth transition, and we really appreciate the continued opportunity we have to dialog with you on this.

[The prepared statement of Dr. Barbe follows:]

********** INSERT 1**********

Mr. Burgess. Thank you, Dr. Barbe.

Dr. Opelka, you are recognized for 5 minutes, please.

STATEMENT OF DR. FRANK OPELKA

Dr. Opelka. Chairman Burgess, Ranking Member Green, members of the committee, on behalf of the 80,000 members of the American College of Surgeons, we appreciate the invitation to share our thoughts with you today.

The American College of Surgeons again expresses our thanks to Congress for the aspects of MACRA which have eliminated the sustainable growth rate and led to efforts designed to link payment more closely to quality and value. Congress' efforts have not only reduced maximum penalties, your efforts seek to phase in new incentives and provide potential for positive updates. Particularly noteworthy are the congressional efforts to combine and simplify value-based goals for measuring quality improvement. After all, we measure, so that we can improve, not just get paid. We also appreciate the congressional directives for moving from fee-for-service to alternative payment models. We would wish CMS would improve their efforts to work with the American College of Surgeons', ACS, physician-focused payment model. We are mindful of Congress' interest in oversight of CMS's implementation of MACRA.

In order for clinicians to assume risk in value-based payment programs, physicians must have reliable and valid measures of both quality and the cost of care. The American College of Surgeons seeks to support the congressional intent of MACRA

through our work product for building meaningful quality measures for surgical patients and surgeons, as well as proffering the CMS our APMs which are based on true total cost of care.

The American College of Surgeons began over 100 years ago, when America had more hospitals than we have today. They were small and care was not standardized. To standardize quality, we formed the College of Surgeons, and we created the first hospital accreditation. In later years, this became The Joint Commission. Today, we continue those verification programs in order to promote standards for quality of care in trauma centers, such as Level I, Level II, and Level III trauma centers.

Neither the federal government nor commercial payers do much to recognize the over 200 quality standards we create to maintain a national trauma system for this country. Our verification programs are a model which measure what matters to patients. We measure the team and the totality of care. We worry less about measuring the individual surgeon and focus more about measuring the outcome to patients. We, then, credit the entire team with its successes and we use the knowledge gained from our programs to create learning networks which teach others and spread improvement widely, none of this recognized in payment programs.

In much the same way, we have created cancer verification, breast care verification, bariatric care, pediatric surgical care, and now more. Yet, CMS offers meaningless measures which do little to help the surgical patient. CMS feels constrained

from measuring team-based measures, instead seeking simply constructed measures such as surgeons having to track patients' immunizations, rather than measuring the surgical team. The end result is measures become meaningless, burdensome, and distractions. Hospital CEOs end up defunding valued surgical quality programs to chase the wrong measures, simply because that is how they get paid.

It is time we, as the American College of Surgeons, seek congressional directives for CMS to build a strong surgical quality program for each major surgical domain, just as the College has done in our team-based models for hospitals for trauma, for cancer, and more. It is time that we measure what matters. It is time for payment models to align with clinical care and not force clinical care to conform to payment.

Lastly, the American College of Surgeons serves as a leader in digital information and health IT. We are focused on patient-centered digital records, not just EHRs, since patients' lives exist in more than one EHR. This calls for an expansion of our thinking beyond EHRs into a world of interoperability, connecting patients across EHRs, across smart devices, across clinical registries, for activities such as clinical decision support, machine learning, and artificial intelligence. There is so much more we can do for quality and for lowering cost by leveraging digital information. We have to stop thinking of EHRs and think beyond them. We could use your support in promoting

this level of interoperability to make an interoperable digital patient medical record. We look forward to working with the Congress to help surgeons care for patients.

Thank you very much.

[The prepared statement of Dr. Opelka follows:]

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

Mr. Burgess. Thank you, Doctor.

And, Dr. Rai, you are recognized for 5 minutes, please.

STATEMENT OF DR. ASHOK RAI

Dr. Rai. Chairman Burgess, Ranking Member Green, and distinguished members of the Energy and Commerce Committee on Health, thank you for the opportunity to testify today.

I am Dr. Ashok Rai, and I am here today as Chair of AMGA, which represents multi-specialty medical groups and integrated delivery systems. Our membership provides care for one in three Americans.

I am a board-certified internist with 17 years of experience, providing care to patients in Green Bay, Wisconsin. Since 2009, I have served as the President and CEO of Prevea Health, a multi-specialty medical group which employs more than 350 providers, including 60 medical specialties. In total, we employ more than 2,000 people, and I am proud of the impact we have on the people of Wisconsin.

I wanted to express my appreciation to Congress for repealing the SGR formula for Medicare Part B payments. The annual SGR cliffs were obstacles to sound planning and hindered our ability to make strategic decisions that would help us care for patients.

I applaud the committee's leadership role in passing the much-needed MACRA law which puts providers on a path towards value-based care. We agree with Congress that the current fee-for-service payment system is not sustainable, nor is it good for our patients. We need to move to a system where the payment

aligns with the way medical groups focus on the health of a population, rather than only the sickness of patients.

Under MACRA, CMS combined existing programs such as the physician quality reporting system, the value-based modifier, and meaningful use programs to create the merit-based incentive payment system, better known as MIPS. Under the MACRA statute, MIPS providers would have the opportunity to have positive or negative payment adjustments based on their performance, starting at plus or minus 4 percent in 2019 and eventually plus or minus 9 percent in 2023.

By putting provider reimbursement at risk, I believe Congress intended to move Medicare to a value-based payment model where high performance was rewarded and poor performers were incented to improve with lower payment rates. In fact, high-performing groups like Prevea Health have been preparing for this value transition for years by participating in MIPS's legacy programs such as PQRS, VM, and MU. As a result, our efforts to perform in these legacy programs have improved the value of care provided through increased quality and decreased cost.

But the problem we face now as healthcare providers is that CMS is excluding a majority of providers from the MIPS program. CMS has bypassed the intent of MACRA by excluding 58 percent of providers from MIPS requirements for performance year 2019 and the recently-proposed quality payment program, or MACRA rule. This will result in the 2021 payment year adjustment being around

2 percent for high-performers, instead of closer to 7 percent, which the statute dictates. Last year, CMS excluded 60 percent of eligible clinicians, which collapsed the potential reward for high-performers from 5 percent to 1.5 percent.

To give you a real-life example of how this works, in the four Tax Identification Numbers that Prevea Health bills under in partnership with our hospital partners, Hospital Sisters Health System, Prevea Health scored three perfect scores of 100 and one of 97. However, because of the MIPS exclusions, our payment adjustment was only 2 percent. Why is this important? To get to value, to create change is incredibly difficult. It requires changes in how we deliver care, how we set up our administrative and financial processes. It means investing millions of dollars in information technology and people. Importantly, it requires buy-in from every member of the team, especially the providers.

The changed management challenges presented by creating a new value-based delivery system are enormous. And Prevea Health undertook this challenge because we viewed MACRA as the incentive program that would reward us for making these changes and doing well by our patients. Now, though, I have to go back to the physicians and providers at my group and say the investments we made, they weren't rewarded. The better care we delivered was not recognized. That is a difficult message to deliver, and I don't think that is the message that this committee or Congress

wanted us to make, but it is the one we have to tell providers at Prevea because of the way MACRA is being implemented.

I appreciate the concerns so ably expressed today by my colleagues for physicians practicing in solo or smaller practices. The reporting burden on them is real. However, I have to point out that the MIPS program is a continuation of quality programs that have been in existence for years, and no one is excluded from these programs, certainly not 58 percent of them. I firmly believe Congress passed MACRA to push the transition to value in Medicare Part B. Ironically, by excluding the majority of clinicians from MIPS, if anything, we have taken a step back from this transition. These exclusions need to end. Only then can MACRA meet your goal of moving Medicare meaningfully towards value. AMGA stands ready to work with Congress and CMS to ensure MIPS, and MACRA, serves as the transition tool to value, as it was intended to be.

Thank you.

[The prepared statement of Dr. Rai follows:]

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

Mr. Burgess. Thank you, Doctor.

Dr. Parekh, you are recognized for 5 minutes, please.

STATEMENT OF DR. PARAG PAREKH

Dr. Parekh. Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee, thank you for the opportunity to provide feedback on MACRA implementation.

I am here today on behalf of the Alliance of Specialty Medicine, a coalition of 15 medical specialty societies, representing more than 100,000 physicians and surgeons. My name is Dr. Parag Parekh. I am a private-practicing eye surgeon in rural western Pennsylvania and the only board-certified, fellowship-trained ophthalmologist specializing in cataract and refractive surgery as well as cornea and glaucoma surgery in that entire geographic area. I chair the Government Relations Committee of the American Society of Cataract and Refractive Surgery, one of the alliance member organizations.

The alliance greatly appreciates your leadership to repeal the SGR, create MACRA, and revamp the legacy quality reporting programs. Listening to physicians' concerns, Congress created MIPS, which streamlined the existing programs and allows physicians to focus on the measures and activities that most closely align with our practices. Successful implementation and long-term viability is important, since MIPS is the only pay-for-performance option for many specialists. We also appreciate the technical corrections advanced earlier this year, which strengthen the law, continue progress made to date, and

will improve the ability of specialty physicians to engage in quality improvement activities.

MACRA provides two value-based reimbursement tracks for physicians under Medicare. Under one, physicians an opt to remain in fee-for-service and participate in MIPS. In the other, physicians can participate in advanced alternative payment models. For many specialists, including ophthalmologists like me, MIPS is the only meaningful and viable pathway. Many specialists have no opportunities to participate in advanced APMs, given that they are designed with a primary care focus.

While there is always more work to be done, many specialists have made significant strides to deliver high-quality and efficient care. In the last 50 years, ophthalmologists have made tremendous strides in cataract surgery by reducing complications and the variations in cost. Ophthalmology has developed meaningful outcomes measures, including for cataract surgery, which are being reported through the MIPS program. And CMS proposed to include cataract episode cost measures as well. Therefore, it is critically important that Congress maintain a viable fee-for-service option in Medicare Part B, along with the MIPS program, to ensure that specialists can continue to meaningful engage in the quality improvement initiatives and deliver high-quality care.

The MIPS technical corrections gives CMS additional flexibility to determine the appropriate weight of the MIPS cost

category, allow CMS to gradually increase the performance threshold before reaching the mean or median standard, and exclude Medicare Part B drugs from MIPS payment adjustments and eligibility determination.

However, additional modifications are needed to support more meaningful measures and lessen the complexity of reporting and scoring. Currently, clinicians must comply with four performance categories, each with distinct requirements and scoring methodologies. Allowing clinicians to get credit across multiple MIPS categories by engaging in a single set of actions would make the program much less confusing.

For example, tracking outcomes through a clinical data registry and using such data to improve patient care should count for multiple categories of MIPS. Alliance specialty societies continue to invest heavily in the development of quality measures, including outcome measures and those reported by patients, and have established robust clinical data registries that have been qualified for use in the MIPS program. In my own specialty, the American Academy of Ophthalmology has the IRIS registry, which serves as a key tool in reporting MIPS data and tracking outcomes.

Measure implementation is another ongoing challenge. Our member societies continue to develop new specialty-focused measures, but CMS threatens to eliminate them when they do not immediately produce enough data to set reliable performance benchmarks. In addition, for more established measures

previously developed by specialties, CMS has determined some of them to be topped-out and, then, remove them from the program, even though these measures continue to improve care and continue to be meaningful to specialty physicians. Removing them from the program limits our ability to participate in MIPS.

Finally, the alliance opposes MedPAC's recommendation to eliminate the MIPS program and replace it with the voluntary value program, which relies on population-based measures geared towards primary care and eliminates the one program, MIPS, that specialists can actually use to demonstrate and improve their quality and overall value. The VBP would discourage specialists from developing relevant quality and outcomes measures, disincentivize the use of high-value clinical data registries to track patterns of care, and thwart efforts to collect and report performance data.

Again, thank you for your work to ensure successful and timely implementation of MIPS.

[The prepared statement of Dr. Parekh follows:]

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

Mr. Burgess. Thank you, Doctor.

And, Dr. Ransohoff, you are recognized for 5 minutes, please.

STATEMENT OF DR. KURT RANSOHOFF

Dr. Ransohoff. Thank you, Chairman Burgess, Ranking Member Green, and esteemed members of the committee, for inviting me to present today.

For the last few years, my group, Sansum Clinic in Santa Barbara, California, has been on a journey going from the SGR payment system to become a devoted MIPS provider, only to evolve into a Track 1+ ACO. Our journey will provide some insight into what is good and what is less good about the recent shifting of the tectonic plates on which the Medicare physician payment system stands.

Before going further, let me tell you about me and my group. I am a general internist. I have practiced in the same exam rooms for the last 26 years. I have been doing this long enough to recall handwriting my patient progress notes and to have cared for multiple generations of families. I have been able to say to a 70-year-old man, "Your murmur sounds exactly like your dad's did at your age." I have been honored to have practiced for that long in the same setting.

Sansum Clinic is a nearly 100-year-old not-for-profit medical foundation with 200 doctors. It is an oddity in that it is not affiliated with a hospital. We have participated in the whole alphabet soup of modern health insurance from HMOs to PPOs, to ACOs.

For the last two years, I have been the Board Chair of America's Physician Groups. APG is a professional association representing more than 300 of the nation's most advanced medical groups in the country, many of whom take full financial risk in caring for their patients.

With that background, let me return to our story of our journey from the SGR days to being a Track 1+ ACO. Whatever criticisms there are about MIPS and MACRA, almost all doctors will say thank you, as all of us have, to Congress for doing away with that flawed process. In the SGR days, our budgeting process was basically chaos. The cut that was generated by the formula would mean that we would be entirely unable to balance our books. So, we just ignored it and prayed that the implementation would be put off, as it was every year, usually at the 11th hour. We also had a great sigh of relief when the SGR was repealed.

Then, there was this new process, MACRA, on the scene. Over the last few years, our clinic became a very successful MIPS participant. We got 100 and we made lot of investments in care processes to enhance the health of our populations and patients. And yet, we have left MIPS and we have gone on to become a Track 1+ ACO. The details in the journey are included in my remarks, but I will try to summarize the take-home messages of our journey.

What have we learned? SGR was really problematic, and though there remains some issues within the MIPS program that need to be addressed, it is far and away a better system than

the dreaded "doc fix" gamble that we all had to rely on for years. The way MIPS has been implemented is not the way it was planned. It is an asymmetric process. The intended larger reward for high scorers is gone, but the intended large loss for those who score poorly is still there. Most of that is because so many doctors are excluded from MIPS, more than half a million, according to The Federal Register.

We fully recognize that exemptions are necessary in some cases, but this level of exemptions undermines the spirit of the law and impedes the goal of moving our nation's healthcare system to value. There are real benefits to the patients and to the healthcare system that come from the clinical processes that are put in place to try to do this work well. At the same time, the metrics on which doctors are graded need to be relevant for their specialty and their practice.

Here are a few suggestions that we think can encourage the movement from volume to value:

Lower the threshold for excluding groups entirely from MIPS and, thereby, increase the number of physicians participating in the program. At the same time, in recognition of the fact that smaller groups have fewer resources, MIPS for smaller groups may need to look different than MIPS for larger groups. In other words, give smaller groups a different test more suitable for their resources, instead of excluding them entirely.

Even if there are flaws in MIPS, there is value for individual

patients and populations and, importantly, the payer of all of this, the American taxpayer, in encouraging data collection and encouraging the use of, and the reporting of, high-quality and high-value care. The processes that are created to do that will help move Medicare from volume to value. We should find ways of making it feasible for more providers to participate in that process, instead of excluding them. MIPS can and should be fixed. It should not be discarded.

Thank you for allowing me to speak, and I will be happy to answer any questions.

[The prepared statement of Dr. Ransohoff follows:]

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

Mr. Burgess. Thank you, Dr. Ransohoff.

I don't see our chairman or the ranking member of the full committee back yet. So, we will proceed with the question-and-answer portion of the hearing. If either the chairman or the ranking member do show up, we will, obviously, yield to them for their statements as well.

And I, again, want to thank each of you for being here.

Many of you have mentioned different milestones along the journey that took us from where we were in the early 2000s to where we are now. I will just say, when I first got here, the goal of repealing the SGR became one my primary focus, and early on it was to repeal the sustainable growth rate formula. I thought if I replaced that with the Medicare Economic Index plus an inflation factor every year, so MEI plus 1 sounded reasonable to me, pretty simple and straightforward. So, that was my original proposal. The Congressional Budget Office threw about $300 billion of cold water on that idea, and I attracted no supporters, and I literally was pursuing that by myself, I think through two Congresses.

So, that is part of what led to the journey of where we are now. Obviously, things have happened along the way. The PQRS, many of you mentioned having to come to a conclusion at the end of every year and provide a "doc fix". And how many remember PQRS in 2006 was sort of Bill Thomas' parting gift to medicine, if I can use that term? But PQRS was to pay for the "doc fix,"

right? That is how we got PQRS, and PQRS is one of those legacy programs that now finds itself in MIPS.

One of the largest contacts I get on social media is about a new payment rule for labs in Medicare, and I appreciate that it is causing some stress. That is based upon a provision in what was really literally the last "doc fix" in 2014, a bill called PAMA that, again, provided the dollars to bring us to "doc fix".

So, underscoring everything else, the SGR is gone and we are not having to deal with the "doc fix" at the end of the year, as I think, Dr. Barbe, you mentioned having to go to your banker every year and explain, "Well, it isn't really going to happen." Right? "They say it, but it isn't really going to happen." So, that burden also has been lifted. And now that it is no longer there, we kind of forget that it was something that literally it was the end of every Congress every December of every year that I was here for quite some time.

So, having provided that background, obviously, I am going to ask the easy question first, and I do want everyone to answer. In the tradition of Chairman Dingell, I am going to make this a yes-or-no question. Better off today under the system that we have or were we better off under the SGR legacy?

Dr. Barbe, I will start with you. Better off today?

Dr. Barbe. Much better.

Mr. Burgess. Dr. Opelka?

Dr. Opelka. Absolutely.

Mr. Burgess. And Dr. Rai?

Dr. Rai. We are better today.

Mr. Burgess. That is an affirmative.

Dr. Parekh?

Dr. Parekh. Much, much better.

Mr. Burgess. Affirmative also.

And Dr. Ransohoff?

Dr. Ransohoff. A rare opportunity for five doctors to agree.

[Laughter.]

Mr. Burgess. Okay. I wasn't going to do this, but you reminded me. One of my greatest wishes is to someday come into this committee hearing, having five doctors at the table who are going to discuss how economists should be paid.

[Laughter.]

We will save that for another day. This group gets it.

The economists don't think that is funny, and I have tried that on them from time to time.

So, no program is absolutely perfect, and I appreciate, I guess, Dr. Ransohoff, your journey that took you, first, to the direction of the small practice and, then, to the alternative payment method.

And I will also add, as we were going through the discussions that led to this bill finally getting firmed up, I believed it would take 10 years in this process. Once again, I had a simple

formula; let's do 10 years with a 1-percent update every year. That seemed like a good fit. Again, the CBO threw a bunch of cold water on that idea, and it was condensed down to five years at a .5-percent update, which actually got a little further lowered after that. But I always thought it would take longer.

This is a big change, and more than just having the change and having the bill signed, it is important to get it right. And I hope, if nothing else, this hearing today -- this is the fourth hearing we have had on the implementation of this law. And if anyone at the agency is listening, I want them to understand this as well. It is important that we get it right. It is not important that we passed the bill and that we had a signing ceremony down at the White House. It is important that we get it right, because, obviously, patients are counting on it. Obviously, doctors are counting on it, and the taxpayer is also one of the variables in this equation that we have to consider as well.

So, I think I have heard the answer to this question during your testimony, but I will ask you for the record. Would it be better for Congress to continue to work with the agency, with the Centers for Medicare and Medicaid Services, to implement the merit-based system as laid out in statute or just scrap it entirely and go back to the drawing board?

Dr. Barbe, we will start with you.

Dr. Barbe. We are eager to continue to work on this. We

think it has potential.

Mr. Burgess. Thank you.

Dr. Opelka?

Dr. Opelka. Mr. Chairman, quality is a never-ending cycle. We have to continuously work on this.

Mr. Burgess. That is great. Thank you. I am going to steal that quote.

Dr. Rai?

Dr. Rai. I would agree that we need to continue to work with you on MIPS.

Mr. Burgess. Dr. Parekh?

Dr. Parekh. I also agree. In business school, they teach us about continuous quality improvement, and I think that principle applies here, too.

Mr. Burgess. Yes, sir.

Dr. Ransohoff?

Dr. Ransohoff. There is a lot of good to this program, and it should be continued to be worked on.

Mr. Burgess. I have some other questions, but I will submit them for the record.

Just one last story about the journey that got us here. There was one morning when -- he is no longer the Majority Leader -- but the then-Majority Leader came up to me, and I was whining about this problem not having been solved. And he said, "Well, Doc, would it be easier if we put everybody into an ACO?" Well, the short answer to his question is, yes, it would be easier, but it wasn't the right thing.

I appreciate the journey that you have been on, Dr. Ransohoff, and I think that kind of told me what, in fact, I was telling the Majority Leader that morning. We are not quite sure about what the journey that different practices will have to take, and it is important for the entire panoply of practices to be able to prosper in the environment.

And I will yield back and recognize Mr. Green for 5 minutes, please.

Mr. Green. Thank you, Mr. Chairman.

And thank each of you for joining us today.

MACRA was an important step forward for our healthcare system, building on the successes of the Affordable Care Act. One of the key goals was to further reforms that would promote value over volume and incentivize providers to find new ways to offer more coordinated and efficient care. In order to further that goal, MACRA created the Physician-Focused Payment Model Technical Advisory Committee, PTAC, and to make recommendations to the Secretary for proposals for physician-focused payment

models that would help control healthcare spending and improve quality.

Dr. Opelka, can you describe why MACRA and the creation of PTAC was so critical to our efforts toward delivery system reform?

Dr. Opelka. I think the key here is -- and we really appreciate the congressional action to create the physician input into business models -- the care models have changed, and they change every year. They have changed over the last 50 years. The payment model has been stuck from 50 years ago. So, we need to take the care model and put a business model on top of it that works, which means that the payer community, particularly in our case the agency, needs to listen to us and figure out how are we going to incentivize quality; how are we going to reach the congressional goal of value by actually putting a payment model that maps to the care model? And having that relationship, the Congress open that door, and what we need now is for an agency that is willing to, and has the resources to, accept that.

Mr. Green. Does anyone else on the panel want to comment on how it was working with the PTAC?

Yes, sir, Doctor?

Dr. Barbe. Thanks for asking that. As I mentioned earlier, physicians want to be engaged and involved in this process. PTAC was created for that very reason. They have received dozens of proposals that come from the ground level, physicians that are practicing that know what will work in their practices, and

perhaps in their specialty. And yet, none of these have been adopted by CMS or, really, we think given serious consideration. And these span everything from very focused proposals in GI medicine to reduce rehospitalization in Crohn's patients, all the way up to the end-stage renal disease that could have a very broad effect on improving care and reducing costs for dialysis patients. So, we think there is great opportunity there if CMS will listen to us.

Mr. Green. Any other comments?

[No response.]

Which gets me to my point, I want to turn to the CMS decision not to test many of the models that the PTAC has submitted for testing.

And, Dr. Barbe, you get the first one. Can you expand on your remarks in your testimony about the Secretary of HHS decision not to implement or test most of the physician-focused models that PTAC has submitted for testing? Why is it so problematic for MACRA implementation?

Dr. Barbe. So, the original ideas, these very innovative ideas were brought forth from the ground level. PTAC was designed to evaluate these, look at the merit, look at the rigor, and make recommendations. And they have not recommended positively on all of these proposals, but they have recommended positively on 10. Again, up to this point, CMS has not seen fit to continue to work on those, to dialog and say, "Well, this is what we don't

like" or "what we do like about this proposal. If you could change it, maybe we could adopt it." They seem to be interested in coming up with ideas on their own, and I think that is not only reinventing the wheel potentially, but it is not taking advantage of some very creative and innovative proposals that have come forward.

Mr. Green. Anyone else?

Yes, sir, Dr. Opelka?

Dr. Opelka. So, Congressman Green, we did propose to the PTAC. We were early on accepted. We were, then, accepted in a letter by the Secretary for consideration by the Innovation Center. The Innovation Center had a few conference calls with us and one two-hour in-person meeting on a product that we developed that took almost five years in the making. There is no resources and no capability in the Innovation Center to complete a design and, then, to create an implementation and have a sandbox or a pilot area in which to test.

And so, the PTAC has done a fantastic job. The Secretary vetted us. And I think we are only one that went from the Secretary and was recommended to the Innovation Center, and it died in there because it is just not wired to really innovate. And we really need to turn that on.

Mr. Green. Dr. Barbe, or anyone else, has the AMA or any other specialty societies received further feedback from HHS or CMS on why HHS is not testing these models that the PTAC has recommended? Have you gotten any feedback other than -- well,

I want to hear from Dr. Barbe.

Dr. Barbe. We have submitted just a month ago a four-page letter outlining what we believe are some merits of a few of the very specific proposals that PTAC recommended on up to CMS. And while they acknowledge receipt of those, they acknowledge the work that the PTAC has done, they really have not offered any explanation. As I said, we would be happy to work through PTAC with them to modify, if there was a deficiency they saw in the model and they said the idea is good, but it won't go for this reason. I think we are all eager to work with them. We are three years into a six-year program on this particular issue and still don't have a model that physicians can embrace and use that has been approved.

Mr. Green. Mr. Chairman, my time is out, but somewhere along the way HHS should clarify and have coordination between not just AMA, but also the specialty societies, because, as you know, specialties sometimes are different than a doctor down the road. And we need to see whether our subcommittee can maybe encourage HHS and CMS to give feedback and coordinate with you on where we are going with this.

Thank you.

Mr. Burgess. I don't disagree. A future hearing that would include both the agency and stakeholders on PTAC issue seems like a good idea.

The Chair recognizes Mr. Guthrie, 5 minutes for questions,

please.

Mr. Guthrie. Thank you very much, Mr. Chairman.

Thank you, everybody, for being here.

And I know you have touched on some of this in your opening statements, but I know that the 5 minutes is kind of limited. So, I want to kind of just go back and give you each a chance to kind of ask -- I will do these two questions together.

So, my question is, for each of you, what specifically has each of you done, or are doing, in your own practices to daily set yourselves up for success under MIPS, and if you went through MIPS and out of MIPS specifically? And what can physicians do right now to position themselves to succeed in MIPS?

So, I will just start with Dr. Barbe. Or, no, let me go right to left, since we went the other way. Dr. Ransohoff, I will start with you, then, and go left.

Dr. Ransohoff. Thanks. That is an excellent question, Congressman.

I will give an example. We became a patient-centered medical home. We had a long history of capitated care. So, we are a very integrated medical group. But, going into MIPS, even we, who are pretty far along, decided that we needed to have a culture change within our organization. And so, we adopted this PCMH model, which really has changed the way we do things. Our medical assistant, our nurse will, as the patient is coming into the room, will find out have you had a mammogram that we don't

know about; have you had a vaccination that we don't know about. So, we can update it in our system. It is a small thing, but it turns out that is actually an important culture change because it has engaged us in a much more team-focused approach to care. So, that is one example of how MIPS has sort of propelled us along in what we think is the right direction.

Mr. Guthrie. Okay. Thank you.

Dr. Parekh?

Dr. Parekh. Thank you for the question.

I would say that there is a two-pronged approach to answering your question. One is on a personal level, and then, the other one is kind of our professional society. So, within the eye doctor, eye surgeon community, we have, of course, my organization, the American Society of Cataract and Refractive Surgery, and we have the American Academy of Ophthalmology. We work very closely together to develop measures that are relevant to my day-to-day practice and that align very much with what patients want, I think with what you all want, and with what we want in terms of what is best for our patients.

So, part of it is developing outcome measures, which we have, developing cost measures. It is not an easy task. I personally serve on some of these committees. We spend hours and hours and hours on this, but it is hugely important on a global level to have that, your professional society helping to create those measures.

And then, it's like a one-two punch almost. On a personal level, I will tell you, participating in MIPS and getting good scores has not been very difficult. My EMR makes it very simple. I have a coach through my EMR system. We talk regularly. We email regularly. I can keep track of my score of how I am doing this year. And so, having the good measures is very important, and then, having a good EMR system, and then, just putting forth the personal effort to pay attention to those measures. And then, improve my deficiencies, become a better surgeon, become a better doctor, and also keep track of those measures. So, it has been a two-pronged approach.

Mr. Guthrie. Thank you.

Dr. Rai?

Dr. Rai. So, to answer your first question, what have we done to prepare for MIPS and MACRA, really, it is redesigning how we practice. The physician is no longer the center of the healthcare system. The patient should be. And we have redesigned all of our practices, both primary care and specialty care, to put the patient in the middle and establish team-based care, making sure that nurse care managers are interacting with patients, making sure that if you have a chronic disease, your visit never ends. It is just how often we connect with you.

And we have also made significant investments in data infrastructure. An EMR without the ability to draw the data in is just a really expensive word processor. And we have had to

make significant investments in drawing the data out, but, then, also make significant digital investments that are patient-facing and forward to identify gaps in their care, to establish online scheduling, all of which we have done in this last year.

Your other question, what should other physicians do to prepare, really, it is no longer focusing on the sickness of our patients, but the health of our population. We need to make more investments on keeping people out of the hospital, even out of our clinics, which isn't always financially viable, but we, through MACRA, through MIPS investments, are rewarded for that. And we have to use those value rewards to redesign how we practice medicine.

Mr. Guthrie. Okay. Thanks.

Dr. Opelka, we are about out of time. So, go ahead, if you have got a couple --

Dr. Opelka. Very quickly, for the most part, MIPS does not measure surgical care. So, we do the best we can to help our surgeons get the credit they need for payment purposes, but, then, we try to refocus them on the quality metrics programs that we have separate from MIPS.

Mr. Guthrie. Okay. Dr. Barbe, do you have just one quick thought?

Dr. Barbe. Our group has been very successful, but we have invested heavily over a decade in order to be successful. I am concerned that some of these programs now simply don't give

physicians enough upside opportunity to invest like that in order to be successful.

Mr. Guthrie. Okay. Thank you.

And I yield back.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for your questions, please.

Mr. Schrader. Well, thank you, Mr. Chairman.

Dr. Rai, why are 58 percent of the practices excluded from MIPS? What is your opinion?

Dr. Rai. I think CMS created those exclusions because physicians felt they weren't ready to participate. But, for MIPS to be successful, for MACRA to be successful, there has to be a plus and a negative. It is a budget-neutral program. So, there has to be a carrot and a stick.

The 58 percent really came from CMS --

Mr. Schrader. But why are they excluded? Why are they not ready?

Dr. Rai. Why are they not ready? I think some consider themselves not ready because they have not made the investments or are willing to make the investments or take the risks that are involved in now making that transition from fee-for-service to value.

Mr. Schrader. Investments in terms of expensive computers,

or whatever, or what are you talking about?

Dr. Rai. I think the investments are multi-fold. I think probably the most significant investment that we have made is in people, in making sure that we redesign how we practice healthcare. It is in staff. It is not only in staff, but in --

Mr. Schrader. So, it is basically a decision by those offices not to engage, frankly, in the new era of modern medicine?

Dr. Rai. It is. It is. It is people that would really like to hang onto fee-for-service for as long as they can.

Mr. Schrader. All right. All right.

So, I guess, Dr. Parekh, why is MIPS the only option for a specialist? I would understand that you are not a primary home model type of thing, but why is that the only APM? Or why doesn't some other form of APM work for you?

Dr. Parekh. Again, I will give you my answer, multiple key reasons. First and foremost, most practically speaking, there are no APMs in my area that I could join, even if I wanted to.

Mr. Schrader. Sure.

Dr. Parekh. So, there is just a geographic barrier to that. You will know better than I about the spread of those APMs through the country, but, certainly, in my area it is just not a choice.

The ACOs are very primary care-focused. When I think of how an ACO works and what the potential is to save money and to improve quality of care, it makes the most sense for primary care

to be doing that because they are the quarterbacks of the team. They help coordinate the entire ship. My wife is an internist. I mean, we have this discussion at the dinner table all the time.

When we in ophthalmology are trying to improve our patients' care, I mean, think of it from our perspective. I am trying to do a good job on cataract surgery. I am trying to lower my patient's eye pressure from glaucoma, so that they don't go blind. But, if we were in a big model, those measures are likely not going to be used. So, they wouldn't actually do anything for my patients. They wouldn't actually give me a solid, meaningful measure that I could do, I could measure myself; I could say, oh, I am deficient; I want to improve. That is not going to exist because the system is so big. So, I think we lose something when you have such a massive system. The primary care gets the weight of that in these bigger systems and I think the specialists are lost.

MIPS, on the other hand, gives me a measure that directly affects what I do. I mean, if I am --

Mr. Schrader. Do you interface with primary care systems at all? Is there any primary care system in your geography?

Dr. Parekh. No.

Mr. Schrader. Okay. All right. In rural Oregon, we have been able to make that happen. I am not talking to your situation, but just for the sake of the panel and others, there are ways to make APM systems work, ACOs work in rural settings. It is

a culture, and after a while you figure out how to do it, like you all are doing as you adopt new practices and stuff.

So, Dr. Ransohoff, you suggested maybe lowering the exclusion threshold in the MIPS program. Could you elaborate on that a little bit? To my investments, I mean, I would assume that the outcomes, whether you are a large practice or a small practice, the outcomes shouldn't really change. If it is patient-centered, you want the patient to be healthy, less readmissions, less time between surgeries, whatever the option is. Could you talk a little bit about that?

Dr. Ransohoff. Yes. I think that the main issue is just trying to get more doctors involved in the process. The way it is set up now, in a way what you have is you have a bunch of people who are believers, if you will, and are kind of going down that path, and then, you have a bunch of people who are just saying, "Thank goodness this doesn't affect me," and are not making any efforts to change.

Mr. Schrader. Right.

Dr. Ransohoff. I think that, in the absence of change, I don't understand how any of this gets to be affordable. And so, I do think there is going to have to be some change. By lowering the threshold from $90,000 to some number less than that, you would start a gradual transition. People would know it was coming.

I do think that, as my colleague here in solo practice points

out, I think that this is doable. It is just that people don't want to do it.

Mr. Schrader. So, maybe some sort of phase-in with the thresholds, so that people can see a path or eventually develop a path going forward?

Dr. Ransohoff. Correct.

Mr. Schrader. So, the last question real quick, Dr. Barbe, everyone has pretty much referenced electronic medical records and EHR. I am very, very concerned that, while individual practices and groups are making huge investments -- originally, there was some money from the federal government to help out; gone now. Maybe that is something we should continue or think of strictly for small practices. But I am concerned about the systems -- and you guys have alluded to this -- not talking to one another. And there is a vested interest, with all due respect to our EHR developers, to keep that system pretty proprietary and pretty unique, so that you have got to buy their stuff. Could you talk a little bit about trying to broaden that out? Is there a role for the federal government to require some of these developers to make it easier for doctors to share their information across specialties, primary care, frankly, nutritionists, the whole gamut?

Dr. Barbe. So, yes, we believe the Office of the National Coordinator can facilitate better interoperability. Many groups are trying workarounds now, all the way from health information

exchanges to other cloud-based. Dr. Opelka earlier referenced activities of the American College of Surgeons. The AMA has significant activities around an IHMI, or Integrated Health Model Initiative, that we believe has some great potential. But all of those are workarounds because the industry has not made data interoperable and, in fact, has blocked data in many cases.

Mr. Schrader. Thank you. And my time is up, but I think that is a critical issue for this committee to address, if we are going to be successful going forward.

Thank you very much, Mr. Chairman.

Mr. Burgess. Thank you, Dr. Schrader.

I would just point out that the third title in the Cures bill that we were planning on having oversight of the implementation was the electronic health records. We did have the mental health title evaluation earlier this week, I think, or was it last week? But, in any case, that has been held up because a rule has been stuck at the Office of Management and Budget, and we had initially planned to have that hearing in June and it was postponed because of that reason. Then, we are eventually just likely going to have to have the hearing without the rule having been finalized or released by OMB.

I would now like to recognize the gentleman from Illinois, the chairman of the Subcommittee on Energy and Environment, Chairman Shimkus, 5 minutes.

Mr. Shimkus. Thank you, Mr. Chairman. This is a great

hearing. Tough names out there. So, if I butcher them, I apologize for that.

For Dr. Schrader, I think we do need to look at this as an exemption issue. If this is a movement forward, and there are cost challenges, we ought to get everybody onboard on the quality bandwagon.

I can't remember who mentioned it in their opening statement, but someone, one of you mentioned that high-performers are not getting rewarded. Can you just address that a minute? Because, obviously, you mentioned, I think -- correct me if I am wrong -- poor-performers are being identified, but high-performers are not being rewarded.

Dr. Rai. Yes, I think both Kurt and I mentioned that. At the end of the day, for the budget neutrality to work, there has to be just as many people involved in this. And that is what the exclusions created, was the incentive was cut in half for high-performers. Because there weren't as many people in there, the threshold was changed. So, from expecting a 4-percent to a 2-percent increase, yet making all the investments to value, is where we felt that high-performers were literally being penalized for making the right investments.

Mr. Shimkus. Any more? Dr. Ransohoff, I am going to go with you to the next question, too. So, why don't you answer that also?

Dr. Ransohoff. Yes, we have the same issues. We spent

probably half -- we will get a 2.02-percent reward for getting 100 -- we probably spent half of that trying to get it. Now we had done that because we thought that the reward would be significantly more, and it is the right thing to do, but there is an economic issue with it.

Mr. Shimkus. Yes, and I am going to talk economics a little bit, too. But I want to go back. What intrigued me about your comment to another question was, electronic health records or whatever, EMR, or whatever you want to call them, asking patients about indices that they may not be there for. We have been dealing with that with the opioid issue and trying to change law, so that there is a little more conversation. As you all know, there are catastrophic stories of the firewall between information, which has turned out deadly, and this whole committee has been trying to do things that we can do to address that. So, I applaud that, and hopefully, the legislation that we are moving forward, hopefully, with the Senate concurrence and a presidential signature, will start making that a little more available.

The concern is always going to be data privacy, personal privacy, and the like. So, you are the folks in the field and you are the ones who have to really help us see and help direct us on protection versus sharing of information throughout the practice. Especially if we are doing a patient center, as you guys were mentioning, holistic, with different people around, that information has to be shared throughout the practice. So,

excellent point.

I wanted to ask, I wanted to kind of go off, not totally off-script, and I am not trying to get this partisan or political, but in this current world today how much is, what are you paying -- how do you want to answer this question. I have always been worried about uncompensated care. Even with a government-run healthcare policy, high deductibles, can you talk to me about -- and that is all the time I am going to have. So, whoever wants to talk to me about, even in a system where we are doing Medicare and Medicaid, that doesn't pay costs, even if we are moving to high performance. So, if we are not paying the cost of care, and then, you have folks, and then, you are eating uncompensated care, that is where I think our system just breaks down. Anyone want to talk about uncompensated care or charity writeoffs, or however you want to define it?

Dr. Barbe. So, what the AMA would like to see is no uncompensated care not from our side, but because that means patients have coverage that will help them get access to care. That is the bottom line here. So, it is not a matter of how we handle uncompensated care. It is how do we get more people covered, so that they can have access?

Mr. Shimkus. Quickly, anybody else want to jump in? Everybody else is compensated fully and there are no writeoffs? That is what you are saying? Or you just don't want to go into this debate right now?

Dr. Opelka. Well, you have opened up a very complex subject matter.

Mr. Shimkus. Yes, right.

Dr. Opelka. The bottom line is that the uncompensated care patients, when they come in to seek surgical care, it is already too late. They are way behind the power curve. And that is the most unfortunate thing. We all see them. We all treat them. We take care of them.

Mr. Shimkus. We should take care of them in the internist level or early intervention and provide that care --

Dr. Opelka. Their cancers are diagnosed late. So, they have a poor outcome. Let's get in front of the disease, and the uncompensated care patients come in a day late and a dollar short.

Mr. Shimkus. My time has expired. Thank you, Mr. Chairman.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back.

The Chair will recognize the gentlelady from California, Ms. Matsui, 5 minutes for questions, please.

Ms. Matsui. Thank you, Mr. Chairman.

And I thank the witnesses for being here today.

We were talking about telehealth, and a group of us on the Energy and Commerce worked together to advance telehealth legislation, legislative and with the administration. As we have worked on legislative efforts, we have found CMS and CBO to be resistant to expanding access to telehealth due to cost concerns.

Expansion has often been judged as adding a new service that could be overbilled, rather than taking into account that reducing hospital and ER visits would result in better care that could result from getting patients access to care sooner and more conveniently.

I am encouraged that CMS has taken steps in this recently-proposed rule to expand access to telehealth in Medicare, as this is what we have been working toward. There will be no way to prove success in the Medicare population without covering services. And I am curious to hear from our witnesses about the types of telehealth services that they currently implement.

Starting with you, Dr. Barbe.

Dr. Rai. I would be happy to start.

Currently, in our organization we provide telestroke coverages to rural hospitals.

Ms. Matsui. Okay.

Dr. Rai. We also are opening up very small cities in Wisconsin, northern Wisconsin, so just Ladysmith at the new site, and we would love to provide more services to there. Some of our specialists live 5 to 6 hours from there --

Ms. Matsui. Right.

Dr. Rai. -- but easily could provide followup services or counseling services. There is not a lot of times in medical specialties especially, such as endocrinology, that we generally

necessarily need to examine the patient. We need to be able to have that conversation and counsel that patient, or other services that are not even physician-based. But, unfortunately, we run into the wall with CMS and other payers without an ability to pay for that infrastructure, which does not come cheap. But we have done it with telestroke. We have done it. We have done it very well. We hope to do more.

Ms. Matsui. Okay. That is great.

Anyone else want to comment on that?

Dr. Barbe. So, there are many types of services and sites of services --

Ms. Matsui. Right.

Dr. Barbe. -- that are actually prohibited from participating in telehealth or digital medicine. We can start by getting rid of some of those restrictions. We can start by unbundling some of these payment codes, so that we can charge differently for consults versus remote patient monitoring.

Ms. Matsui. Right.

Dr. Barbe. My particular group is very robust in what we call virtual care, which is digital medicine, and we put monitoring devices in patients' home. We will even run the internet to their home, because in rural southern Missouri many don't have that. So, there are a lot of things, but we can's do this because there is no direct payment. The only reason we can do it now is we are in some risk-sharing arrangements.

Ms. Matsui. All right. Anyone else here?

Dr. Opelka. Just very quickly, where there are capitated environments, all these barriers to payment go away, and telehealth actually becomes very creative and innovative. In a capitated environment, in my former practice we dealt with rural, like was mentioned, but we also dealt with prisoners, and putting telehealth in the prison became a very effective way of getting better care to the prisoner, rather than having to transport somebody with all kinds of guards and other security. Telehealth was a savior.

Ms. Matsui. Okay. Let me just go on. One of my legislative efforts with Representative Bill Johnson on Energy and Commerce is H.R. 3482, which would remove originating site and geographic restrictions on telehealth in Medicare. And the steps CMS has taken to pay for virtual check-ins is very much in line with this idea. We passed a limited version of that bill for opioid service in the House opioids packages, and I hope the Senate will move to take this important legislation. And I really do look forward to having it expand further, and I think it would be helpful for all of you.

I have been working to advance interoperability between electronic health records, and the proposed rule has implemented a performance measurement in order to promote interoperability. I guess, Dr. Opelka, you have talked about this. What success have providers had in working toward a goal of interoperability?

Do you feel that the implementation of MACRA has been helpful?

Dr. Opelka. I don't know that MACRA itself has actually drawn attention to this. When we moved away from dealing with the EHRs and we created a patient cloud, and we began moving data into the cloud environment, in which we could represent information either to a patient or to a clinician from wherever that patient was seen, those models are now emerging separate from the EHR vendors. It is making a huge difference in care in those environments. That is the direction we need to go in, and that is where we need to actually educate the government to help us push incentives that drive us more to a patient cloud environment, rather than to say, this hospital, this EHR, it is this patient and all the hospitals they get care in.

Ms. Matsui. Right. Okay.

I think I have run out of time. I yield back. Thank you.

Mr. Burgess. The Chair thanks the gentlelady. The gentlelady yields back.

The Chair recognizes the gentleman from Ohio, Mr. Latta, 5 minutes for questions, please.

Mr. Latta. Thank you. Thank you, Mr. Chairman. I want to thank you for the hearing today.

And I want to thank all of you for being with us today. Because I am sitting here looking at you thinking to myself of all the patients you would be seeing right now in the time that you are taking to testify before us on this important matter.

One of the great things that we get to do, we travel around in our districts. We talk to our docs back home. And we also have the ability to see a lot of the third-year, four-year medical students from our states come through. They are working on a lot of their specialties and everything else, but, at the same time, they kind of bring up with you all the sundry things that they are going to have to be doing to practice medicine.

And I wonder if you all would mind answering a question for me, just going down the line, if you wouldn't mind. How much time do you take out, if you took a percentage, that you are practicing medicine or you are doing the administrative side of your job?

Dr. Barbe. I can answer that very precisely. The AMA has done two studies. It shows that physicians spend about two hours in front of their computer screen or doing other paperwork for every hour they have in direct clinical contact. We did a second study that shows, for primary care physicians, they spent 60 percent of their day in non-direct-patient-care activities.

Dr. Opelka. And it is roughly about 20 percent of their time doing administrative burden.

Dr. Rai. It is ballpark around that same number. We at our own organization started to look at EMR utilization after 5:00 or 6:00 p.m., when they log in from home after dinner, and how long they are on it. A significant amount of our primary care physicians are logging in late at night to complete their

day, which is definitely leading to a nationwide situation with burnout.

Dr. Parekh. I will echo the comments. I mentioned earlier my wife is an internist, and the kids go to bed around 9:00 p.m. and we get on our computers.

Dr. Ransohoff. We have done the same kind of study. We see that internists, it varies somewhat by specialty, but in primary care it is not uncommon for doctors to spend 20 hours a week after hours doing documentation on the computer.

Mr. Latta. And I know they are calling votes on us right here. I am going to ask just one question then. The clinical data registries and the certified EHRs that are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare, would these represent a decrease in that administrative burden then? And just go down the line.

Dr. Barbe. They haven't yet. The EHRs still just don't work for physicians. There is too much point, click, move from one field to the next. Even in the certified technologies, which we have, we are still burdened significantly by that.

Dr. Opelka. So, the clinical data registries, we run about seven international registries. They actually pull data in and generate knowledge, and that knowledge is delivered at the moment of care that allows for clinical decision support, that allows for better care, higher quality, et cetera. So, while they may take on time, they actually reduce burden and improve patient

outcome. So, they are very welcome.

Dr. Rai. I would echo that. The registries are welcome. They help us identify gaps in care that patients may need on an active basis, on a more timely basis, and the ability to access a patient to make sure that we get in front of them before they get in front of us in an acute situation.

Dr. Parekh. As I mentioned in my testimony, the Academy of Ophthalmology created the IRIS, I-R-I-S, registry, and it has been a huge help. I will give you an example. Let's say, two days ago, I was doing surgery. My EMR records the date of the surgery on the right eye, for example. And then, when we see the patient back, of course, we record how the vision is doing. And one of our measures is, is the patient 24/40 or better within 90 days? So, it is an outcome measure, like I said, very important to our speciality, very important to our patients. And so, as soon as that vision reaches that threshold, the EMR automatically captures that data. The point is, we are getting outcomes data and it is very little additional work because the registry is able to grab that info without me typing it in again for the registry. So, it has been great.

Dr. Ransohoff. There is nothing faster than ineligible handwriting that is not shared with anyone.

[Laughter.]

And I practiced in those days. The computer systems that are out there now are more time-consuming. I do think they are

much better.

I prescribed recently -- the patient was on two unusual medications, and they computer said there is going to be a drug interaction. And so, there are real benefits to it, but it is definitely more time-consuming.

Mr. Latta. Okay. Well, Mr. Chairman, my time has expired, and I yield back.

And I thank our witnesses again for spending time with us today. Thank you.

Mr. Burgess. The gentleman yields back. The Chair thanks the gentleman.

The Chair does acknowledge there is nothing faster than bad handwriting, particularly if you are lefthanded.

The Chair now recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. Eshoo. Thank you, Mr. Chairman.

And thank you to the witnesses. You represent so many that practice medicine across our country in the different disciplines, and have headed up, and do head up, organizations that are representing them.

I would like to go to Dr. Rai and Dr. Ransohoff with this question. Earlier this month, CMS released a proposed rule that estimated that 42 percent of physicians participating in Medicare will need to comply with MACRA. So, my question to both of you is, with so many physicians that are exempt from both APMs and

MIPS, has CMS undermined the original intent of MACRA? Would that be your take? And with so many physicians exempt, will MACRA meet the original payment reform goals it set out to achieve?

Dr. Rai. I do believe CMS has gone against the intent of MACRA with the exemptions. For this to work, for us to truly move to value, the intent of MIPS, as one of my colleagues has been quoted to say, MIPS was the on-ramp to value and CMS has created an exit ramp.

Ms. Eshoo. Why do you think they are doing this?

Dr. Rai. I think because the move -- change is never easy. The change of going from fee-for-service to value, to taking risks --

Ms. Eshoo. Oh, we have been doing that for a long time. This isn't exactly something that happened in the last 90 days. I mean, we have been in transition since I first came into the Congress on this thing, and I have been here for a while.

Dr. Rai. I don't disagree with you at all. The legacy programs did not have the exemptions. And now, all of a sudden, we are exempting people, and it is truly preventing -- it is another kick-the-can-down-the-road. It is becoming SGR 2.0 if they continue that behavior.

Ms. Eshoo. Well, how do you think CMS can improve the MIPS implementation?

Dr. Rai. Implement it as it was written. I mean, really implement what you passed.

Ms. Eshoo. Great. Good answer. Good. All right. Well, that is confidence in the work that we have done, Mr. Chairman.

To Dr. Opelka and Dr. Parekh -- is it "Parak" or "Paresh"?

Dr. Parekh. Parekh.

Ms. Eshoo. Parekh.

I have heard from physicians in my congressional district -- it is the Silicon Valley district in California -- that those in small practice and who practice specialty care face barriers in participating in MIPS. Do you face barriers, as some of my physicians have reported? And if so, what are they?

Dr. Parekh. Thank you for the question.

As an ophthalmologist, again, I feel very lucky. We have amazing professional societies. We have been working for a long time, as you said, coming up with measures. I mean, we have been preparing for this moment for a while, coming up with outcomes measures, coming up with process measures, creating cost measures, having a registry. So, I am very fortunate -- knock on wood; I thank our professional societies -- it hasn't been that hard for us in ophthalmology.

Ms. Eshoo. Well, that is good. Do you know Dr. Chang?

Dr. Parekh. Dr. David Chang.

Ms. Eshoo. Dr. David Chang, yes.

Dr. Parekh. Yes, he is one of my very good friends. In fact, he knew that I was coming today and sent me a very kind email.

In ophthalmology, I think our numbers to some extent back up what I am saying. I think people who participated in our registry, I think 85 percent got a score of 100, getting the 2 percent that was mentioned earlier, and I think 99 percent got some type of bonus. So, again, we have been working hard at this, very hard at this, and I think it is blossoming.

Ms. Eshoo. Would you recommend anything to us that would lessen the burden on physicians, so that you can more actively participate in MIPS or do you think it is just working swimmingly?

Dr. Parekh. I think there is always room for improvement.

Ms. Eshoo. Always, yes.

Dr. Parekh. Like I said, it is a continuous quality improvement mindset that we have to have.

Ms. Eshoo. But do you have something, anything specific? Anyone have anything specific?

Dr. Opelka. Sure. So, this whole matter of participating or exclusions, if you don't measure what matters, putting money and investments into something that is senseless, nobody wants to participate.

Ms. Eshoo. And that is what we are doing?

Dr. Opelka. So, all the surgical specialties, all of them, including ophthalmology, the majority of their measures have nothing to do with surgical care.

Ms. Eshoo. Wow.

Dr. Opelka. They are measuring primary care. So, it

doesn't surprise me that primary care says everyone should be in, but it also doesn't surprise me when surgery care says, "It doesn't matter to the patients I am treating. So, why am I spending money in my practice to send CMS tobacco cessation and immunization rates?" Nobody comes to me as a surgeon with breast cancer to talk about those things. We are not measuring what matters. And so, as long as we are going to measure silly things, everyone is going to say, "I want to be excluded." If you want to measure what matters, put me in. Put me in, coach. I want to play. But that is not what we are getting.

Ms. Eshoo. Well, I think that that is highly instructive to us, Mr. Chairman.

Mr. Burgess. That is the reason we are having the hearing.

Ms. Eshoo. Yes. Well, that is what happens in hearings.

Mr. Burgess. And I appreciate your --

Ms. Eshoo. But what I am suggesting is that we work with CMS to get rid of what was just described as the -- did you use the word "silliness"?

Dr. Opelka. Yes.

Ms. Eshoo. Okay. Thank you to all of you. I mean, you are the healers of the nation. So, thank you for what you have devoted yourselves to, and taking on the extra responsibility of heading up organizations.

Mr. Burgess. If the gentlelady will conclude her soliloquy --

Ms. Eshoo. Thank you.

Mr. Burgess. -- we have about a minute left on a vote on the Floor.

Ms. Eshoo. I yield back.

Mr. Burgess. I am going to recess after I acknowledge the presence of Dr. Boustany, former Member of Congress and member of the Ways and Means Committee. We appreciate your attendance here today.

And we will stand in recess until after this vote.

[Recess.]

Mr. Guthrie. [presiding] The committee will come back to order. Thank you.

There will be other members that are voting and will be back shortly to ask questions, but we are going to continue the question period.

All right. The Chair recognizes Dr. Bucshon for 5 minutes to ask questions.

Mr. Bucshon. Thank you, Mr. Chairman. I appreciate that.

And thank you to all the witnesses for being here. I was a cardiothoracic surgeon before coming to Congress, and this is critically important for our patients at the end of the day, right? And that is what I try to focus on.

As you know, the participation in MIPS is low. Everyone outlined roughly 60 percent of physicians are excluded from the program, leaving only $118 million of the $70 billion baseline

for incentive payments for practices. Participation in the alternative payment models in MACRA is even smaller, with only 5 percent of physicians enrolled in an APM. CMMI has not approved a single APM submitted from PTAC, and PTAC cancelled its June meeting due to lack of APMs to review.

I am interested in ways to increase participation in and the number of APMs, which is why I introduced the Medicare Care Coordination Improvement Act, H.R. 4206, which three of you on the panel's organizations have signed a letter in support of -- and I will get to that in a minute -- which would encourage development, testing of participation in APMs by exempting practices from the volume and value prohibitions in the Stark law. After all, how can practices deliver on value-based care if they cannot remunerate their physicians based on value?

Mr. Chairman, I ask unanimous consent to submit the letter to the record.

Mr. Guthrie. Without objection, so ordered.

[The information follows:]

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

Mr. Bucshon. The American College of Surgeons, the American Medical Association, and AMGA, amongst many others, have signed onto the letter.

Basically, it says they are in strong support of the act that we introduced and "The legislation would substantially improve care, coordination for patients, improve health outcomes, and restrain costs by allowing physicians to participate and succeed in alternative payment models." The bill would modernize the Stark self-referral law enacted nearly 30 years ago.

The things that it would do is provide HHS with the same authority to waive the prohibitions of the Stark law and associated fraud and abuse laws for physicians seeking to develop and operate APMs, as was provided for ACOs in the Affordable Care Act; remove the volume or value prohibition in the Stark law, so that physician practices can incentivize physicians to abide by best practices and succeed in the new value-based alternative payment models. This protection would apply to physician practices that are developing or operating an alternative payment model, including the advanced APMs, APMs approved by the physician-focused payment model, the Technical Advisory Committee, MIPS APMs and other APMs specified by the Secretary; and finally, ensure that CMS's use of current administrative authority promotes care coordination, quality improvement, and resource conservation.

I guess I will ask the question of everyone. How do you

think changes to the Stark law would help physicians coordinate and improve care and help MACRA succeed? And how important do you think that would be in the overall success of what we are trying to do with the MACRA legislation and, also, as you have noted, transition to an outcome-based, patient-centered-based way to reimburse providers?

I will just start that. If any of you aren't aware of what we have done, that is okay. But we can start with the surgeons.

Dr. Opelka. Thank you very much.

First of all, yes, we are in strong support of this effort. Specifically, the way that Stark is written, you can be held accountable without intent, and that is a problem. So, when we have alternative payment models with shared savings opportunities between all the parties, legal counsel, when they review these contracts, become extremely worried about how clean are these waivers or exemptions from Stark. They have got to be bulletproof because Stark is so broad and overreaching, it is easy for a court to interpret things different than your own counsel interpreted them.

For that reason, when we go to these alternative payment models where there are parties that will be involved in shared savings, or whatever different payment models are applied, we need to be sure that there is clean, crisp lines that exempt or waivers that are provided for Stark, so the parties can come together. That is really what we see. When we put our own APM

forward to PTAC, we included the need for Stark waivers and the exemptions. But we agree with you and fully support what you are doing.

Dr. Ransohoff. In order to have an ACO, particularly an ACO like this that requires risk-taking and risk-sharing, you need to get a group of physicians together who are willing to work together and share the risk and, also, generally, a hospital. So, you need all of those parties to do that. Then, these laws become a serious impediment to doing that. Just the legal expenses of trying to make sure it is even okay to have a meeting become daunting. So, I think if you are going to encourage doctors and hospitals to try to take risks together in a fee-for-service world, you do need to look at the regulatory barriers that exist.

Mr. Bucshon. All right. Thank you.

Beg your indulgence, Mr. Chairman.

Anyone else have any comments quickly? Anyone else? Yes?

Dr. Rai. Stark made sense in a fee-for-service environment, but if we are truly going to move to value, we need regulatory relief, as explained by my colleagues.

Mr. Bucshon. Okay. Thank you. I appreciate that.

Thanks, Mr. Chairman. I yield back.

Mr. Guthrie. Thank you. The gentleman yields back.

The Chair now recognizes Mr. Griffith of Virginia, 5 minutes for questions.

Mr. Griffith. Thank you very much, Mr. Chairman. I appreciate it.

I appreciate you all being here. With two votes series disrupting the committee, it is tough as witnesses, and I do appreciate your patience.

Let me echo what my colleague just said about the Stark Act. I think it is outdated probably in more ways than most people do. And I find it inhibits some collaboration in rural areas where we are underserved already. And why would we put barriers up?

Does anybody disagree with that statement? I am looking at the entire panel. Just for the record, none of them disagrees with that statement.

All right. Let's see. Given that, now I have got a question that we want to get on the record. On June 29th, CMS allowed MIPS participants to see their performance score based on 2017 reporting. Would each of you please share what your scores were?

Dr. Rai. I would be happy to start since I brought mine with me.

Mr. Griffith. All right. That would be fine.

Dr. Rai. We bill under four Tax ID Numbers because of how we are regionally divided. Three, we scored 100, and on the fourth one we had a 97.

Mr. Griffith. Okay. Anybody else weigh-in who knows? Yes, sir?

Dr. Parekh. I like your question because it also relates to the previous issue of physician participation. I was in a big group practice and I decided to start my own practice. And so, it was the end of 2015 and into 2016 that I was doing that. The 2017 measurement, what you are asking about, is based on your surgical volume or your volume at the end of 2016, but that is when I was starting my practice.

I knew, of course, about our Academy's IRIS registry. I knew myself. I knew that I could do a good job on those measures, but there was no opportunity for me to participate. I couldn't opt-in. I couldn't believe that I couldn't opt-in. So, I asked multiple people. I am like, "Are you sure I can't opt-in? I would love to do this. This is great. That is a good measure." Multiple people assured me I could not.

Mr. Griffith. Okay.

Dr. Parekh. So, unfortunately, I was not eligible, even though I wanted to be.

Mr. Griffith. All right.

Dr. Ransohoff. As I have said before, we bill under a single Tax ID Number, and we did get 100.

Mr. Griffith. Okay. And last, but not least.

Dr. Opelka. I am retired from practice.

Mr. Griffith. Yes? So, no data? All right. I appreciate that. Thank you so much.

My concern, of course, is rural areas, as I mentioned before,

when I was talking about the Stark Act. So, when we are looking at rural areas, can you describe or can any of you illuminate us on the challenges of physicians practicing in the rural areas and the pressures they face to remain in practice? And how do the legacy programs add to those burdens? I mean, I know a lot of the burdens they have already. But how do the legacy programs add to those burdens, and has MIPS eased those burdens? And even if it has eased them a little bit, what else can we be doing to help our rural friends?

Dr. Barbe?

Dr. Barbe. Maybe I will weigh-in on that first. So, I was amazed when MACRA passed and we were looking at MIPS, and we had a lot of physicians come out of the woodwork and say, "Oh, my gosh, how are we going to comply with MIPS?" And I thought in my mind, well, have they not been doing the legacy programs already? And the answer is, no, they hadn't. Hundreds of thousands of physicians didn't participate in all three or didn't participate successfully. So, there are a lot of physicians that are now working to make this transition.

Specifically, with regard to rural, Dr. Opelka said it very well. We need meaningful measures that relate to that individual physician's practice. We need to make them easy to capture, and we need to make them, if you will, activities that are applicable across more than one of those dimensions of MIPS. If you have got a diabetic patient and you are changing your processes and

you are improving care, and you are using an electric record, why don't you get credit across all three domains?

Mr. Griffith. All right. Yes, sir?

Dr. Opelka. Very quickly, the trauma program is a classic example where we have Level I, II, and III levels of service. Typically, in the rural environment we are dealing with a Level III. The number of standards they need to meet are significantly less than the 200-plus standards for a Level I. So, you need to tailor measurement down to the point of care and the care model that that environment has. The MIPS program does not do that. It is a one-size-fits-all program. So, the rural element is no different than, in surgery, it is no different than in the city. They are not meaningful and fit for purpose. And therefore, the surgeons pay attention to it for purposes of payment, but not for the purposes of quality of care.

Mr. Griffith. Okay. Anybody else? Yes?

Dr. Rai. We operate many rural clinics, but because they are part of a larger multi-specialty group, we are able to spread our infrastructure more efficiently to them.

And to your other question about was it easier under MACRA to submit versus the legacy programs, I have talked to our quality department. It was slightly easier this year to submit to CMS. The mechanism of submitting all three at once was easier than the previous legacy format.

Mr. Griffith. So, it was a little bit better?

Dr. Rai. A little bit better, yes, sir.

Dr. Parekh. I would echo all these comments. Understand that rural medicine is very different than urban/suburban. And I know in Washington oftentimes people talk about a bubble in Washington, but coming from central Pennsylvania, it is a very different environment here. I mean, let me tell you, there are hospitals where I can't get internet service. I mean, just think about that statement. And my EMR, of course, is a cloud-based EMR. I mean, this is a true issue. But, again, I think MACRA has certainly helped, to answer the second part of your question.

Mr. Griffith. Other parts of our committee are trying to work on those internet issues.

Dr. Ransohoff?

Dr. Ransohoff. I mean, technically, right now for someone who had just done nothing, MIPS is actually better, just by the algebra of it initially, because the cut would have been less.

But I agree with my colleagues, and I have said previously I think for small practices in rural areas they just need a different -- they need relevant standards that resonate with their practice, but they probably need to have a different test, so that they can participate. Fewer measures I think would be a very reasonable approach.

Mr. Griffith. All right. Thank you very much. I appreciate it.

And my time is up and I yield back.

Mr. Guthrie. Thank you. The gentleman yields back.

The Chair now recognizes Mr. Carter from Georgia for 5 minutes for questions.

Mr. Carter. Thank you, Mr. Chairman.

And thank all of you for being here.

Before I begin my questions, I have to say this. Earlier in the hearing there was a conversation about doctors' handwriting. And I just want to say, I want to represent my profession as a practicing pharmacist for over 30 years. So, you get it? You understand what I am saying.

[Laughter.]

Anyway, I couldn't resist that and I apologize. Too many times have I struggled to understand what a doctor was writing.

I wanted to talk to Dr. Rai. Okay, I am sorry. I know I butchered that.

But, nevertheless, as a pharmacist, I am a member of the Doctors Caucus. We had sent a letter to CMS earlier this month about MACRA and MIPS implementation and the $500 million that had been authorized to ensure positive payment adjustments. But one of the things that we have run into is that we just don't have enough physicians who are participating. And I just wanted to ask you. CMS estimates that it is over 60 percent that aren't participating. What are the obstacles? What are some of the obstacles that are preventing or prohibiting providers from switching to this?

Dr. Rai. I think some of the obstacles are inherent to how they have been practicing medicine and how their own structures have been developed over time. Some may say they have not followed the legacy programs, as was mentioned earlier. So, they have not actually implemented the EMR or using it in a meaningful way. They have not developed patient-centered medical homes or have the ability to tap into registries. There are a variety of reasons why people are not participating.

But for us to truly move to value, we need everybody to participate. MACRA was written to be a carrot-and-a-stick program. So, for it to work, everybody has to be in.

Mr. Carter. I suspect that I would be correct to say that it is worse in rural areas than it is in urban areas. Is that correct?

Dr. Rai. I haven't seen CMS's distribution of who is not participating, but I think it is across the board. I think you will see it in small single specialty in a very urban area. But, yes, you will probably see it a lot in urban areas that don't have a system infrastructure supporting them.

Mr. Carter. Okay. Can you describe very briefly about some of the investments that your organization has made in order to participate in this?

Dr. Rai. I can break the investments into three categories, the first being people. The most important category in healthcare is continuously investing in people. Team-based care

is not inexpensive -- nurse care managers, extra medical assistance, making sure the physician or the provider is surrounded by the best people to take care of their population, not just the patient that is in front of them that day.

The next area is, like I mentioned, an EMR is only as good as you can draw the data out of. So, our largest area of investment in the EMR is not really the EMR anymore. It is digital platforms to draw the data out, to analyze it, to hopefully someday get access to claims data, which we need, to be able to look at a risk population and predict what is going to happen to a patient before it happens to them.

And the third area of investment is that digital platform that is patient-facing. Our patients want access to their record. It is not our medical record; it is their medical record. It is creating environments for them to interact with us in virtual care, like we launched this year, where they don't have to come into the office.

Those have been the three categories of investments that we personally made to make sure we are successful not only with MACRA, but with value down the line.

Mr. Carter. Right. Thank you.

Dr. Parekh, I wanted to ask you, in your testimony you had mentioned that MedPAC had made the recommendation that MIPS should be replaced with a voluntary value program that might be phased in over time. And I just wanted to ask you -- and in full

disclosure, I agree with you; I don't agree with MedPAC. I think that would be the wrong route for us to go. I think we are headed in the right direction with this. We ought to figure out a way, I think, if not to incentivize, then to require physicians to do this. And I don't like that. I don't like the heavy-handed government, particularly in healthcare. But, at the same time, I am convinced we are moving in the right direction.

I just wanted to ask you, what are some of the challenges to developing outcome measures in the practice of medicine?

Dr. Parekh. It is just hard. It is hard to do. You have to have a clean measurement. You don't want all these other comorbidities that are, quote/unquote, "messing up your outcomes". So, let's take cataract surgery, for example. If I have a patient who has got severe blinding macular degeneration at baseline, and then, they have developed a cataract on top of that, as bad as it originally was, now it is worse. So, I take their cataract out and I get them maybe to 2400, which is the big "E", legal blindness still. They are ecstatic, but my measure might look bad because, "Oh, Dr. Parekh, this patient, you operated on them and they are legally blind." So, things like that, those subtleties, the devil is in the details.

Mr. Carter. Right.

Dr. Parekh. Those subtleties make all the difference. So, coming up with those kind of clean outcomes is very hard to do.

Mr. Carter. Right.

Dr. Parekh. And so, there are certain surgeries that lend themselves to that, but others that don't.

Mr. Carter. I am out of time. But I want to thank all of you for your efforts in moving this forward, because I do believe it is we are headed in the right direction with this.

And I yield back.

Mr. Guthrie. Thank you. The gentleman yields back.

Seeing there are no further members wishing to ask questions, I would like to thank you all for being here today. As somebody mentioned earlier, you are missing a lot of patients today to be here to inform us, but it is important that you do.

And I would like to submit the following documents for the record: American Academy of Dermatology Association, letters from the American Academy of Family Physicians, the American College of Physicians, Connected Health, American Society of Clinical Oncology, Infectious Disease Society of America, and Medical Group Management Association.

Mr. Green. No objection, Mr. Chairman.

Mr. Guthrie. Without objection, so ordered.

[The information follows:]

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

Mr. Guthrie. Pursuant to committee rules, I remind members that they have 10 business days to submit additional questions for the record, and I ask that witnesses submit their response within 10 business days of receipt of the questions.

Without objection. Mr. Green. Mr. Chairman, I would just like to recognize a family from my district, the Garcia family. We spend a whole lot of time in these committee meetings. But I thank them for coming here.

Mr. Guthrie. Welcome. Welcome to Washington. Thanks for being here.

So, without objection, the subcommittee is adjourned.

[Whereupon, at 12:13 p.m., the subcommittee was adjourned.]