Welcome to today's hearing to give us a chance to checkup on the implementation of Medicare Access and CHIP Reauthorization Act of 2015, commonly abbreviated to MACRA.

I believe we are in a better place now than we were prior to 2015 because of the work done by the Members of Energy and Commerce, led by Dr. Burgess, to get MACRA enacted into law with overwhelming bipartisan support.

MACRA charted a new course for Medicare and attempted to put it on a more sustainable financial course.

MACRA was designed to shift physician reimbursement from a fee for service payment model to one that seeks to reward doctors for value over volume for patient care.

One of the biggest pieces was the elimination of the Sustainable Growth Rate, or SGR. This was the formula used to determine annual updates to the Medicare fee schedule, which governs physician reimbursement.

On top of eliminating the SGR, MACRA established the Quality Payment Program, which established two pathways to incentivize physicians to transition to value-based care.

One pathway is the Merit-Based Incentive Payment System, or MIPS, where a provider is subject to a performance-based payment system that results in payment adjustments based on certain quality reporting categories.

The other pathway is the Alternative Payment Models, or APMs, which allows physicians to take a risk-based approach to treating patients to achieve specific performance goals in order to receive bonus payments.

This hearing will allow Congress to understand what's working, what's not working, what's showing promise, and what unexpected challenges have come to light.

Among these unexpected challenges is CMS's implementation of MACRA that has created additional levels of administrative complexity and costs.

This has slowed down the adoption of MACRA's quality payment programs.

Savings achieved to date under these models have also been less than was hoped for, and CMS's process for approving new payment models has been something of a disappointment as well.

In 2020, less than 238,000 providers were participating in APMs, while over 933,000 participated in MIPS.

MIPS has also proven administratively complex to implement and costly for providers.

This has disadvantaged small and rural healthcare providers and, in many instances, prevented them from participating in the program on a level playing field.

It is essential that these rural and underserved providers are not left at a disadvantage due to the lack of resources and infrastructure.

A small rural practice needs standards that are relevant to their practice and different than a large suburban practice.

This risks further accelerating the consolidation of health care providers.

We've seen too often doctors are being forced to pay attention to certain metrics to ensure reimbursement rather than for quality of patient care.

We must strike the right balance between fairly compensating our doctors and health care providers to ensure access to high-quality care while also being good stewards of Medicare funds.

I will now yield my remaining time to a leader on this issue, Dr. Burgess.