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6 MACRA AND MIPS: AN UPDATE ON THE MERIT-BASED

7 INCENTIVE PAYMENT SYSTEM

8 THURSDAY, JULY 26, 2018

9 House of Representatives,

10 Subcommittee on Health,

11 Committee on Energy and Commerce

12 Washington, D.C.

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16 The subcommittee met, pursuant to call, at 10:00 a.m., in

17 Room 2123 Rayburn House Office Building, Hon. Michael Burgess

18 [chairman of the subcommittee] presiding.

19 Members present: Representatives Burgess, Guthrie, Shimkus,

20 Latta, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Hudson,

21 Collins, Carter, Green, Engel, Matsui, Castor, Schrader, Kennedy,

22 Eshoo, and Pallone (ex officio).

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23 Staff present: Mike Bloomquist, Staff Director; Samantha
24 Bopp, Staff Assistant; Adam Buckalew, Professional Staff Member,
25 Health; Daniel Butler, Legislative Clerk, Health; Jordan Davis,
26 Senior Advisor; Adam Fromm, Director of Outreach and Coalitions;
27 Caleb Graff, Professional Staff Member, Health; Jay Gulshen,
28 Legislative Associate, Health; Ed Kim, Policy Coordinator,
29 Health; Ryan Long, Deputy Staff Director; Drew McDowell,
30 Executive Assistant; James Paluskiewicz, Professional Staff,
31 Health; Brannon Rains, Staff Assistant; Jennifer Sherman, Press
32 Secretary; Josh Trent, Chief Health Counsel, Health; Hamlin Wade,
33 Special Advisor, External Affairs; Jeff Carroll, Minority Staff
34 Director; Tiffany Guarascio, Minority Deputy Staff Director and
35 Chief Health Advisor; Una Lee, Minority Senior Health Counsel;
36 and Samantha Satchell, Minority Policy Analyst.

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

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

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

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

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59 As an OB/GYN prior to coming to Congress, I was frustrated
60 with the annual exercise of the sustainable growth rate formula,
61 as were many other physicians, as were Members of Congress. I
62 would like to take a moment to remind members of what the world
63 of physician payments looked like before the repeal or before
64 the passage of the Medicare Access and CHIP Reauthorization Act.

65 Congress consistently passed legislation to override the
66 SGR. That resulted in hundreds of billions of dollars spent that
67 could have gone to bolstering Medicare and other health programs.

68 Medicare providers and their patients by extension were under
69 the constant threat of payment cuts under the sustainable growth
70 rate formula. The formula's unrealistic assumptions of spending
71 and efficiency have plagued the healthcare profession and our
72 Medicare beneficiaries for a long time.

73 The Medicare Access and CHIP Reauthorization Act repealed
74 the SGR, provided for statutory updates to allow improved
75 beneficiary access, and got medicine to concentrate on moving
76 to broad adoption of a quality reporting system. One of the most
77 important provisions in the law was a shift from a fee schedule
78 system towards a merit-based incentive payment system. The law
79 left behind a pass/fail quality reporting regime whose measures
80 were too often set up against a one-size-fits-all generic standard

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81 of care with no financial upside for providers.

82 Since the merit-based system was set to go into full effect
83 on January 1st, 2019, the first payment consequence year, from
84 reporting provided in 2017, it is critical that we hold this
85 hearing and hear from our witnesses, in a sense, what is working,
86 how the transition is progressing, and where improvements have
87 been made while seeking ways to simultaneously encourage stronger
88 participation and reward providers already invested in the MIPS
89 track.

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

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

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103 providers to the program.

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

111 In continuing to follow the Medicare Access and CHIP
112 Reauthorization Act implementation, certain decisions were made
113 by the Centers for Medicare and Medicaid Services that were for
114 the benefit of a smooth transition, but had consequences,
115 consequences that affected the agency's trajectory of setting
116 the performance threshold. Given this and other developments,
117 I believe that the law would benefit from technical updates to
118 improve the implementation based on real-time factors. The
119 Bipartisan Budget Act of 2018 included three technical fixes.

120 This was done by myself, Ranking Member Green, and
121 Representatives Roskam and Levin from the Ways and Means
122 Committee.

123 The Medicare Access and CHIP Reauthorization Act changed
124 the world of Medicare provider payments. It has laid the

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125 groundwork for increased access to quality care for beneficiaries
126 by eliminating the uncertainty of the past, reducing physician
127 burden, and providing incentives where previously there were
128 none. It was never a law that was going to be fully implemented
129 with the flip of a switch or a signing ceremony. It was designed
130 as a long-term effort to move the Medicare program down the value
131 continuum.

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

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

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

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

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

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147 be patched annually by Congress.

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

159 Critically, MACRA encourages providers to move away from
160 fee-for-service and participate in a new delivery model that would
161 reduce costs while increasing quality. Under the law, physicians
162 who treat Medicare beneficiaries have a choice between
163 participating in MIPS or the advanced alternative to payment plan,
164 APMs, to make the shift from fee-for-service and volume-based
165 payment system to a value-based payment system. MIPS streamlined
166 three prior quality incentive programs that were sunset in 2016
167 and have been replaced by a new MIPS category, quality,
168 improvement activities, meaningful use, and cost.

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

182 Under MACRA, the Department of Health and Human Services
183 is required to set the performance threshold by 2019 at the mean
184 or median of final scores for all MIPS-eligible clinicians. In
185 February, Congress passed legislation changing the timeline to
186 ease the burden of the MIPS transition. The Bipartisan Budget
187 Act of 2018 granted HHS an additional three years to ensure
188 gradual, incremental transition to the mean or median of
189 performance.

190 I look forward to hearing from our panelists regarding their

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191 experience with MIPS and recent changes made by Congress, whether
192 additional action is necessary to ensure physicians participating
193 in MIPS is generating savings to Medicare and improving patient
194 outcomes.

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

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

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

201 [Recess.]

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

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

207 Each witness is going to have the opportunity to give an
208 opening statement, followed by questions from members. Today
209 we will hear from Dr. David Barbe, the Immediate Past President
210 of the American Medical Association; Dr. Frank Opelka, Medical
211 Director, Quality and Health Policy, American College of
212 Surgeons; Dr. Ashok Rai, Chairman of the Board, American Medical

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213 Group Association; Dr. Parag Parekh, American Society of Cataract
214 and Refractive Surgery, and Kurt Ransohoff, Chairman of the Board,
215 America's Physician Groups.

216 We appreciate you being here today, Doctors.

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

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

226

227 STATEMENT OF DR. DAVID BARBE

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

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

235 Physicians are familiar with value-based payment
236 mechanisms. We have been subject to those for over 10 years,
237 starting with PQRI, which was the original quality-based program.

238 That was in 2007. Meaningful use came in in 2009. Value-based
239 payments began in 2013. But each of these programs came in at
240 separate times under separate bills, were never harmonized, never

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241 even contemplated working together. And all of them started as
242 incentive programs, but most of them have transitioned into
243 penalty programs which are additive.

244 As of now, a physician who is not able to perform, for
245 whatever reason, in those programs could be subject to up to
246 11-percent negative adjustment in their Medicare reimbursement.

247 That was simply not sustainable, and we thank you and the others
248 that worked so hard on MACRA in 2015. That is a significant step
249 forward. Not only did it repeal the SGR, as has been noted, but
250 it began to harmonize these programs, bringing them under one
251 administration, if you will, and it also reset, very importantly,
252 the incentive and penalty corridor, such that for performance
253 in the first year of 2017, it was a plus or minus 4 percent,
254 certainly a better opportunity for physicians to succeed under
255 that particular framework. So, we appreciate the work that went
256 into that.

257 We share a common goal with you in seeing that this program,
258 these new quality payment programs are implemented appropriately,
259 that the transition is smooth. Because we believe that the
260 success of these programs has a real opportunity to improve
261 quality for patients, to bend the cost curve. But, for them to
262 be successful, physicians have to be able to succeed under these

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263 programs as well. Again, MACRA took us a significant step toward
264 physician success and improving these programs.

265 In your opening remarks, you mentioned BBA 2018 and the
266 significant improvements and technical fixes that were made.
267 We really appreciated those as well. We will continue to work
268 closely with you because, as you also suggested, this wasn't a
269 one-and-done. This is an evolving process. And hearings like
270 this today, allowing us to update you, are critical in continuing
271 to improve that process for patients, physicians, and for the
272 Medicare program.

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

281 One of the other pretty important parts of what you enabled
282 was for PTAC to consult with physician groups as we develop
283 physician-focused payment models. The PTAC has been doing what
284 you have wanted it to do. They have received dozens of proposals,

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285 and they have even recommended about 10 of those onto CMS.
286 Unfortunately, CMS has not seen fit to adopt any of those yet,
287 and I think it is thwarting the creativity and innovation that
288 physicians are willing to bring to the table. So, we will
289 continue to work with CMS to try to get them to consider and adopt
290 some of those alternative payments models that are
291 physician-focused that PTAC has recommended.

292 And I think, lastly, you may hear some discussion today about
293 the limitation of the upside opportunity to something in the
294 2-percent range, rather than the 4 percent that was originally
295 contemplated. Again, the goal is to help physicians succeed.

296 All of the organizations represented here represent a wide range
297 of physician practices, physician styles. The AMA certainly
298 does. We represent physicians from all specialties, all practice
299 types.

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

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[The prepared statement of Dr. Barbe follows:]

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Mr. Burgess. Thank you, Dr. Barbe.

311

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

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312 STATEMENT OF DR. FRANK OPELKA

313

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

318 The American College of Surgeons again expresses our thanks
319 to Congress for the aspects of MACRA which have eliminated the
320 sustainable growth rate and led to efforts designed to link
321 payment more closely to quality and value. Congress' efforts
322 have not only reduced maximum penalties, your efforts seek to
323 phase in new incentives and provide potential for positive
324 updates. Particularly noteworthy are the congressional efforts
325 to combine and simplify value-based goals for measuring quality
326 improvement. After all, we measure, so that we can improve, not
327 just get paid. We also appreciate the congressional directives
328 for moving from fee-for-service to alternative payment models.

329 We would wish CMS would improve their efforts to work with the
330 American College of Surgeons', ACS, physician-focused payment
331 model. We are mindful of Congress' interest in oversight of CMS's
332 implementation of MACRA.

333 In order for clinicians to assume risk in value-based payment

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334 programs, physicians must have reliable and valid measures of
335 both quality and the cost of care. The American College of
336 Surgeons seeks to support the congressional intent of MACRA
337 through our work product for building meaningful quality measures
338 for surgical patients and surgeons, as well as proffering the
339 CMS our APMS which are based on true total cost of care.

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

348 Neither the federal government nor commercial payers do much
349 to recognize the over 200 quality standards we create to maintain
350 a national trauma system for this country. Our verification
351 programs are a model which measure what matters to patients.
352 We measure the team and the totality of care. We worry less about
353 measuring the individual surgeon and focus more about measuring
354 the outcome to patients. We, then, credit the entire team with
355 its successes and we use the knowledge gained from our programs

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356 to create learning networks which teach others and spread
357 improvement widely, none of this recognized in payment programs.

358 In much the same way, we have created cancer verification,
359 breast care verification, bariatric care, pediatric surgical
360 care, and now more. Yet, CMS offers meaningless measures which
361 do little to help the surgical patient. CMS feels constrained
362 from measuring team-based measures, instead seeking simply
363 constructed measures such as surgeons having to track patients'
364 immunizations, rather than measuring the surgical team. The end
365 result is measures become meaningless, burdensome, and
366 distractions. Hospital CEOs end up defunding valued surgical
367 quality programs to chase the wrong measures, simply because that
368 is how they get paid.

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

376 Lastly, the American College of Surgeons serves as a leader
377 in digital information and health IT. We are focused on

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378 patient-centered digital records, not just EHRs, since patients'
379 lives exist in more than one EHR. This calls for an expansion
380 of our thinking beyond EHRs into a world of interoperability,
381 connecting patients across EHRs, across smart devices, across
382 clinical registries, for activities such as clinical decision
383 support, machine learning, and artificial intelligence. There
384 is so much more we can do for quality and for lowering cost by
385 leveraging digital information. We have to stop thinking of EHRs
386 and think beyond them. We could use your support in promoting
387 this level of interoperability to make an interoperable digital
388 patient medical record. We look forward to working with the
389 Congress to help surgeons care for patients.

390 Thank you very much.

391 [The prepared statement of Dr. Opelka follows:]

392

393 ***** INSERT 2*****

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394

Mr. Burgess. Thank you, Doctor.

395

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

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396 STATEMENT OF DR. ASHOK RAI

397

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

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

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

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

416 I applaud the committee's leadership role in passing the
417 much-needed MACRA law which puts providers on a path towards

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418 value-based care. We agree with Congress that the current
419 fee-for-service payment system is not sustainable, nor is it good
420 for our patients. We need to move to a system where the payment
421 aligns with the way medical groups focus on the health of a
422 population, rather than only the sickness of patients.

423 Under MACRA, CMS combined existing programs such as the
424 physician quality reporting system, the value-based modifier,
425 and meaningful use programs to create the merit-based incentive
426 payment system, better known as MIPS. Under the MACRA statute,
427 MIPS providers would have the opportunity to have positive or
428 negative payment adjustments based on their performance, starting
429 at plus or minus 4 percent in 2019 and eventually plus or minus
430 9 percent in 2023.

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

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440 But the problem we face now as healthcare providers is that
441 CMS is excluding a majority of providers from the MIPS program.

442 CMS has bypassed the intent of MACRA by excluding 58 percent
443 of providers from MIPS requirements for performance year 2019
444 and the recently-proposed quality payment program, or MACRA rule.

445 This will result in the 2021 payment year adjustment being around
446 2 percent for high-performers, instead of closer to 7 percent,
447 which the statute dictates. Last year, CMS excluded 60 percent
448 of eligible clinicians, which collapsed the potential reward for
449 high-performers from 5 percent to 1.5 percent.

450 To give you a real-life example of how this works, in the
451 four Tax Identification Numbers that Prevea Health bills under
452 in partnership with our hospital partners, Hospital Sisters
453 Health System, Prevea Health scored three perfect scores of 100
454 and one of 97. However, because of the MIPS exclusions, our
455 payment adjustment was only 2 percent. Why is this important?

456 To get to value, to create change is incredibly difficult. It
457 requires changes in how we deliver care, how we set up our
458 administrative and financial processes. It means investing
459 millions of dollars in information technology and people.
460 Importantly, it requires buy-in from every member of the team,
461 especially the providers.

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462 The changed management challenges presented by creating a
463 new value-based delivery system are enormous. And Prevea Health
464 undertook this challenge because we viewed MACRA as the incentive
465 program that would reward us for making these changes and doing
466 well by our patients. Now, though, I have to go back to the
467 physicians and providers at my group and say the investments we
468 made, they weren't rewarded. The better care we delivered was
469 not recognized. That is a difficult message to deliver, and I
470 don't think that is the message that this committee or Congress
471 wanted us to make, but it is the one we have to tell providers
472 at Prevea because of the way MACRA is being implemented.

473 I appreciate the concerns so ably expressed today by my
474 colleagues for physicians practicing in solo or smaller
475 practices. The reporting burden on them is real. However, I
476 have to point out that the MIPS program is a continuation of
477 quality programs that have been in existence for years, and no
478 one is excluded from these programs, certainly not 58 percent
479 of them. I firmly believe Congress passed MACRA to push the
480 transition to value in Medicare Part B. Ironically, by excluding
481 the majority of clinicians from MIPS, if anything, we have taken
482 a step back from this transition. These exclusions need to end.
483 Only then can MACRA meet your goal of moving Medicare

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484 meaningfully towards value. AMGA stands ready to work with
485 Congress and CMS to ensure MIPS, and MACRA, serves as the
486 transition tool to value, as it was intended to be.

487 Thank you.

488 [The prepared statement of Dr. Rai follows:]

489 ***** INSERT 3*****

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490

Mr. Burgess. Thank you, Doctor.

491

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

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492 STATEMENT OF DR. PARAG PAREKH

493

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

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

507 The alliance greatly appreciates your leadership to repeal
508 the SGR, create MACRA, and revamp the legacy quality reporting
509 programs. Listening to physicians' concerns, Congress created
510 MIPS, which streamlined the existing programs and allows
511 physicians to focus on the measures and activities that most
512 closely align with our practices. Successful implementation and
513 long-term viability is important, since MIPS is the only

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514 pay-for-performance option for many specialists. We also
515 appreciate the technical corrections advanced earlier this year,
516 which strengthen the law, continue progress made to date, and
517 will improve the ability of specialty physicians to engage in
518 quality improvement activities.

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

527 While there is always more work to be done, many specialists
528 have made significant strides to deliver high-quality and
529 efficient care. In the last 50 years, ophthalmologists have made
530 tremendous strides in cataract surgery by reducing complications
531 and the variations in cost. Ophthalmology has developed
532 meaningful outcomes measures, including for cataract surgery,
533 which are being reported through the MIPS program. And CMS
534 proposed to include cataract episode cost measures as well.
535 Therefore, it is critically important that Congress maintain a

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536 viable fee-for-service option in Medicare Part B, along with the
537 MIPS program, to ensure that specialists can continue to
538 meaningful engage in the quality improvement initiatives and
539 deliver high-quality care.

540 The MIPS technical corrections gives CMS additional
541 flexibility to determine the appropriate weight of the MIPS cost
542 category, allow CMS to gradually increase the performance
543 threshold before reaching the mean or median standard, and exclude
544 Medicare Part B drugs from MIPS payment adjustments and
545 eligibility determination.

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

553 For example, tracking outcomes through a clinical data
554 registry and using such data to improve patient care should count
555 for multiple categories of MIPS. Alliance specialty societies
556 continue to invest heavily in the development of quality measures,
557 including outcome measures and those reported by patients, and

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558 have established robust clinical data registries that have been
559 qualified for use in the MIPS program. In my own specialty, the
560 American Academy of Ophthalmology has the IRIS registry, which
561 serves as a key tool in reporting MIPS data and tracking outcomes.

562 Measure implementation is another ongoing challenge. Our
563 member societies continue to develop new specialty-focused
564 measures, but CMS threatens to eliminate them when they do not
565 immediately produce enough data to set reliable performance
566 benchmarks. In addition, for more established measures
567 previously developed by specialties, CMS has determined some of
568 them to be topped-out and, then, remove them from the program,
569 even though these measures continue to improve care and continue
570 to be meaningful to specialty physicians. Removing them from
571 the program limits our ability to participate in MIPS.

572 Finally, the alliance opposes MedPAC's recommendation to
573 eliminate the MIPS program and replace it with the voluntary value
574 program, which relies on population-based measures geared towards
575 primary care and eliminates the one program, MIPS, that
576 specialists can actually use to demonstrate and improve their
577 quality and overall value. The VBP would discourage specialists
578 from developing relevant quality and outcomes measures,
579 disincentivize the use of high-value clinical data registries

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580 to track patterns of care, and thwart efforts to collect and report
581 performance data.

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

584 [The prepared statement of Dr. Parekh follows:]

585 ***** INSERT 4*****

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586

Mr. Burgess. Thank you, Doctor.

587

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

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588 STATEMENT OF DR. KURT RANSOHOFF

589

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

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

600 Before going further, let me tell you about me and my group.

601 I am a general internist. I have practiced in the same exam
602 rooms for the last 26 years. I have been doing this long enough
603 to recall handwriting my patient progress notes and to have cared
604 for multiple generations of families. I have been able to say
605 to a 70-year-old man, "Your murmur sounds exactly like your dad's
606 did at your age." I have been honored to have practiced for that
607 long in the same setting.

608 Sansum Clinic is a nearly 100-year-old not-for-profit
609 medical foundation with 200 doctors. It is an oddity in that

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610 it is not affiliated with a hospital. We have participated in
611 the whole alphabet soup of modern health insurance from HMOs to
612 PPOs, to ACOs.

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

618 With that background, let me return to our story of our
619 journey from the SGR days to being a Track 1+ ACO. Whatever
620 criticisms there are about MIPS and MACRA, almost all doctors
621 will say thank you, as all of us have, to Congress for doing away
622 with that flawed process. In the SGR days, our budgeting process
623 was basically chaos. The cut that was generated by the formula
624 would mean that we would be entirely unable to balance our books.

625 So, we just ignored it and prayed that the implementation would
626 be put off, as it was every year, usually at the 11th hour. We
627 also had a great sigh of relief when the SGR was repealed.

628 Then, there was this new process, MACRA, on the scene. Over
629 the last few years, our clinic became a very successful MIPS
630 participant. We got 100 and we made lot of investments in care
631 processes to enhance the health of our populations and patients.

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632 And yet, we have left MIPS and we have gone on to become a Track
633 1+ ACO. The details in the journey are included in my remarks,
634 but I will try to summarize the take-home messages of our journey.

635 What have we learned? SGR was really problematic, and
636 though there remains some issues within the MIPS program that
637 need to be addressed, it is far and away a better system than
638 the dreaded "doc fix" gamble that we all had to rely on for years.

639 The way MIPS has been implemented is not the way it was planned.

640 It is an asymmetric process. The intended larger reward for
641 high scorers is gone, but the intended large loss for those who
642 score poorly is still there. Most of that is because so many
643 doctors are excluded from MIPS, more than half a million,
644 according to The Federal Register.

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

653 Here are a few suggestions that we think can encourage the

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654 movement from volume to value:

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

662 Even if there are flaws in MIPS, there is value for individual
663 patients and populations and, importantly, the payer of all of
664 this, the American taxpayer, in encouraging data collection and
665 encouraging the use of, and the reporting of, high-quality and
666 high-value care. The processes that are created to do that will
667 help move Medicare from volume to value. We should find ways
668 of making it feasible for more providers to participate in that
669 process, instead of excluding them. MIPS can and should be fixed.

670 It should not be discarded.

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

673 [The prepared statement of Dr. Ransohoff follows:]

674

675 ***** INSERT 5*****

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676 Mr. Burgess. Thank you, Dr. Ransohoff.

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

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

683 Many of you have mentioned different milestones along the
684 journey that took us from where we were in the early 2000s to
685 where we are now. I will just say, when I first got here, the
686 goal of repealing the SGR became one my primary focus, and early
687 on it was to repeal the sustainable growth rate formula. I
688 thought if I replaced that with the Medicare Economic Index plus
689 an inflation factor every year, so MEI plus 1 sounded reasonable
690 to me, pretty simple and straightforward. So, that was my
691 original proposal. The Congressional Budget Office threw about
692 \$300 billion of cold water on that idea, and I attracted no
693 supporters, and I literally was pursuing that by myself, I think
694 through two Congresses.

695 So, that is part of what led to the journey of where we are
696 now. Obviously, things have happened along the way. The PQRS,
697 many of you mentioned having to come to a conclusion at the end

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698 of every year and provide a "doc fix". And how many remember
699 PQRS in 2006 was sort of Bill Thomas' parting gift to medicine,
700 if I can use that term? But PQRS was to pay for the "doc fix,"
701 right? That is how we got PQRS, and PQRS is one of those legacy
702 programs that now finds itself in MIPS.

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

708 So, underscoring everything else, the SGR is gone and we
709 are not having to deal with the "doc fix" at the end of the year,
710 as I think, Dr. Barbe, you mentioned having to go to your banker
711 every year and explain, "Well, it isn't really going to happen."

712 Right? "They say it, but it isn't really going to happen."
713 So, that burden also has been lifted. And now that it is no longer
714 there, we kind of forget that it was something that literally
715 it was the end of every Congress every December of every year
716 that I was here for quite some time.

717 So, having provided that background, obviously, I am going
718 to ask the easy question first, and I do want everyone to answer.

719 In the tradition of Chairman Dingell, I am going to make this

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720 a yes-or-no question. Better off today under the system that
721 we have or were we better off under the SGR legacy?

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

723 Dr. Barbe. Much better.

724 Mr. Burgess. Dr. Opelka?

725 Dr. Opelka. Absolutely.

726 Mr. Burgess. And Dr. Rai?

727 Dr. Rai. We are better today.

728 Mr. Burgess. That is an affirmative.

729 Dr. Parekh?

730 Dr. Parekh. Much, much better.

731 Mr. Burgess. Affirmative also.

732 And Dr. Ransohoff?

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

735 [Laughter.]

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

740 [Laughter.]

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

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

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

748 And I will also add, as we were going through the discussions
749 that led to this bill finally getting firmed up, I believed it
750 would take 10 years in this process. Once again, I had a simple
751 formula; let's do 10 years with a 1-percent update every year.

752 That seemed like a good fit. Again, the CBO threw a bunch of
753 cold water on that idea, and it was condensed down to five years
754 at a .5-percent update, which actually got a little further
755 lowered after that. But I always thought it would take longer.

756 This is a big change, and more than just having the change
757 and having the bill signed, it is important to get it right.
758 And I hope, if nothing else, this hearing today -- this is the
759 fourth hearing we have had on the implementation of this law.

760 And if anyone at the agency is listening, I want them to
761 understand this as well. It is important that we get it right.

762 It is not important that we passed the bill and that we had a
763 signing ceremony down at the White House. It is important that

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764 we get it right, because, obviously, patients are counting on
765 it. Obviously, doctors are counting on it, and the taxpayer is
766 also one of the variables in this equation that we have to consider
767 as well.

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

774 Dr. Barbe, we will start with you.

775 Dr. Barbe. We are eager to continue to work on this. We
776 think it has potential.

777 Mr. Burgess. Thank you.

778 Dr. Opelka?

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

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

783 Dr. Rai?

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

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786 Mr. Burgess. Dr. Parekh?

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

790 Mr. Burgess. Yes, sir.

791 Dr. Ransohoff?

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

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

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

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

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

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

812 And thank each of you for joining us today.

813 MACRA was an important step forward for our healthcare
814 system, building on the successes of the Affordable Care Act.

815 One of the key goals was to further reforms that would promote
816 value over volume and incentivize providers to find new ways to
817 offer more coordinated and efficient care. In order to further

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818 that goal, MACRA created the Physician-Focused Payment Model
819 Technical Advisory Committee, PTAC, and to make recommendations
820 to the Secretary for proposals for physician-focused payment
821 models that would help control healthcare spending and improve
822 quality.

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

825 Dr. Opelka. I think the key here is -- and we really
826 appreciate the congressional action to create the physician input
827 into business models -- the care models have changed, and they
828 change every year. They have changed over the last 50 years.

829 The payment model has been stuck from 50 years ago. So, we need
830 to take the care model and put a business model on top of it that
831 works, which means that the payer community, particularly in our
832 case the agency, needs to listen to us and figure out how are
833 we going to incentivize quality; how are we going to reach the
834 congressional goal of value by actually putting a payment model
835 that maps to the care model? And having that relationship, the
836 Congress open that door, and what we need now is for an agency
837 that is willing to, and has the resources to, accept that.

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

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840 Yes, sir, Doctor?

841 Dr. Barbe. Thanks for asking that. As I mentioned earlier,
842 physicians want to be engaged and involved in this process. PTAC
843 was created for that very reason. They have received dozens of
844 proposals that come from the ground level, physicians that are
845 practicing that know what will work in their practices, and
846 perhaps in their specialty. And yet, none of these have been
847 adopted by CMS or, really, we think given serious consideration.

848 And these span everything from very focused proposals in GI
849 medicine to reduce rehospitalization in Crohn's patients, all
850 the way up to the end-stage renal disease that could have a very
851 broad effect on improving care and reducing costs for dialysis
852 patients. So, we think there is great opportunity there if CMS
853 will listen to us.

854 Mr. Green. Any other comments?

855 [No response.]

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

859 And, Dr. Barbe, you get the first one. Can you expand on
860 your remarks in your testimony about the Secretary of HHS decision
861 not to implement or test most of the physician-focused models

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862 that PTAC has submitted for testing? Why is it so problematic
863 for MACRA implementation?

864 Dr. Barbe. So, the original ideas, these very innovative
865 ideas were brought forth from the ground level. PTAC was designed
866 to evaluate these, look at the merit, look at the rigor, and make
867 recommendations. And they have not recommended positively on
868 all of these proposals, but they have recommended positively on
869 10. Again, up to this point, CMS has not seen fit to continue
870 to work on those, to dialog and say, "Well, this is what we don't
871 like" or "what we do like about this proposal. If you could change
872 it, maybe we could adopt it." They seem to be interested in coming
873 up with ideas on their own, and I think that is not only reinventing
874 the wheel potentially, but it is not taking advantage of some
875 very creative and innovative proposals that have come forward.

876 Mr. Green. Anyone else?

877 Yes, sir, Dr. Opelka?

878 Dr. Opelka. So, Congressman Green, we did propose to the
879 PTAC. We were early on accepted. We were, then, accepted in
880 a letter by the Secretary for consideration by the Innovation
881 Center. The Innovation Center had a few conference calls with
882 us and one two-hour in-person meeting on a product that we
883 developed that took almost five years in the making. There is

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884 no resources and no capability in the Innovation Center to
885 complete a design and, then, to create an implementation and have
886 a sandbox or a pilot area in which to test.

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

891 And we really need to turn that on.

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

897 Dr. Barbe. We have submitted just a month ago a four-page
898 letter outlining what we believe are some merits of a few of the
899 very specific proposals that PTAC recommended on up to CMS. And
900 while they acknowledge receipt of those, they acknowledge the
901 work that the PTAC has done, they really have not offered any
902 explanation. As I said, we would be happy to work through PTAC
903 with them to modify, if there was a deficiency they saw in the
904 model and they said the idea is good, but it won't go for this
905 reason. I think we are all eager to work with them. We are three

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906 years into a six-year program on this particular issue and still
907 don't have a model that physicians can embrace and use that has
908 been approved.

909 Mr. Green. Mr. Chairman, my time is out, but somewhere along
910 the way HHS should clarify and have coordination between not just
911 AMA, but also the specialty societies, because, as you know,
912 specialties sometimes are different than a doctor down the road.

913 And we need to see whether our subcommittee can maybe encourage
914 HHS and CMS to give feedback and coordinate with you on where
915 we are going with this.

916 Thank you.

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

920 The Chair recognizes Mr. Guthrie, 5 minutes for questions,
921 please.

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

923 Thank you, everybody, for being here.

924 And I know you have touched on some of this in your opening
925 statements, but I know that the 5 minutes is kind of limited.

926 So, I want to kind of just go back and give you each a chance
927 to kind of ask -- I will do these two questions together.

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

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

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

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

947 So, we can update it in our system. It is a small thing, but
948 it turns out that is actually an important culture change because
949 it has engaged us in a much more team-focused approach to care.

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950 So, that is one example of how MIPS has sort of propelled us
951 along in what we think is the right direction.

952 Mr. Guthrie. Okay. Thank you.

953 Dr. Parekh?

954 Dr. Parekh. Thank you for the question.

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

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

971 And then, it's like a one-two punch almost. On a personal

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

982 Mr. Guthrie. Thank you.

983 Dr. Rai?

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

993 And we have also made significant investments in data

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994 infrastructure. An EMR without the ability to draw the data in
995 is just a really expensive word processor. And we have had to
996 make significant investments in drawing the data out, but, then,
997 also make significant digital investments that are patient-facing
998 and forward to identify gaps in their care, to establish online
999 scheduling, all of which we have done in this last year.

1000 Your other question, what should other physicians do to
1001 prepare, really, it is no longer focusing on the sickness of our
1002 patients, but the health of our population. We need to make more
1003 investments on keeping people out of the hospital, even out of
1004 our clinics, which isn't always financially viable, but we,
1005 through MACRA, through MIPS investments, are rewarded for that.

1006 And we have to use those value rewards to redesign how we practice
1007 medicine.

1008 Mr. Guthrie. Okay. Thanks.

1009 Dr. Opelka, we are about out of time. So, go ahead, if you
1010 have got a couple --

1011 Dr. Opelka. Very quickly, for the most part, MIPS does not
1012 measure surgical care. So, we do the best we can to help our
1013 surgeons get the credit they need for payment purposes, but, then,
1014 we try to refocus them on the quality metrics programs that we
1015 have separate from MIPS.

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1016 Mr. Guthrie. Okay. Dr. Barbe, do you have just one quick
1017 thought?

1018 Dr. Barbe. Our group has been very successful, but we have
1019 invested heavily over a decade in order to be successful. I am
1020 concerned that some of these programs now simply don't give
1021 physicians enough upside opportunity to invest like that in order
1022 to be successful.

1023 Mr. Guthrie. Okay. Thank you.

1024 And I yield back.

1025 Mr. Burgess. The Chair thanks the gentleman. The
1026 gentleman yields back.

1027 The Chair recognizes the gentleman from Oregon, Dr.
1028 Schrader, 5 minutes for your questions, please.

1029 Mr. Schrader. Well, thank you, Mr. Chairman.

1030 Dr. Rai, why are 58 percent of the practices excluded from
1031 MIPS? What is your opinion?

1032 Dr. Rai. I think CMS created those exclusions because
1033 physicians felt they weren't ready to participate. But, for MIPS
1034 to be successful, for MACRA to be successful, there has to be
1035 a plus and a negative. It is a budget-neutral program. So, there
1036 has to be a carrot and a stick.

1037 The 58 percent really came from CMS --

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1038 Mr. Schrader. But why are they excluded? Why are they not
1039 ready?

1040 Dr. Rai. Why are they not ready? I think some consider
1041 themselves not ready because they have not made the investments
1042 or are willing to make the investments or take the risks that
1043 are involved in now making that transition from fee-for-service
1044 to value.

1045 Mr. Schrader. Investments in terms of expensive computers,
1046 or whatever, or what are you talking about?

1047 Dr. Rai. I think the investments are multi-fold. I think
1048 probably the most significant investment that we have made is
1049 in people, in making sure that we redesign how we practice
1050 healthcare. It is in staff. It is not only in staff, but in
1051 --

1052 Mr. Schrader. So, it is basically a decision by those
1053 offices not to engage, frankly, in the new era of modern medicine?

1054 Dr. Rai. It is. It is. It is people that would really
1055 like to hang onto fee-for-service for as long as they can.

1056 Mr. Schrader. All right. All right.

1057 So, I guess, Dr. Parekh, why is MIPS the only option for
1058 a specialist? I would understand that you are not a primary home
1059 model type of thing, but why is that the only APM? Or why doesn't

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1060 some other form of APM work for you?

1061 Dr. Parekh. Again, I will give you my answer, multiple key
1062 reasons. First and foremost, most practically speaking, there
1063 are no APMs in my area that I could join, even if I wanted to.

1064 Mr. Schrader. Sure.

1065 Dr. Parekh. So, there is just a geographic barrier to that.
1066 You will know better than I about the spread of those APMs through
1067 the country, but, certainly, in my area it is just not a choice.

1068 The ACOs are very primary care-focused. When I think of
1069 how an ACO works and what the potential is to save money and to
1070 improve quality of care, it makes the most sense for primary care
1071 to be doing that because they are the quarterbacks of the team.

1072 They help coordinate the entire ship. My wife is an internist.
1073 I mean, we have this discussion at the dinner table all the time.

1074 When we in ophthalmology are trying to improve our patients'
1075 care, I mean, think of it from our perspective. I am trying to
1076 do a good job on cataract surgery. I am trying to lower my
1077 patient's eye pressure from glaucoma, so that they don't go blind.

1078 But, if we were in a big model, those measures are likely not
1079 going to be used. So, they wouldn't actually do anything for
1080 my patients. They wouldn't actually give me a solid, meaningful
1081 measure that I could do, I could measure myself; I could say,

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1082 oh, I am deficient; I want to improve. That is not going to exist
1083 because the system is so big. So, I think we lose something when
1084 you have such a massive system. The primary care gets the weight
1085 of that in these bigger systems and I think the specialists are
1086 lost.

1087 MIPS, on the other hand, gives me a measure that directly
1088 affects what I do. I mean, if I am --

1089 Mr. Schrader. Do you interface with primary care systems
1090 at all? Is there any primary care system in your geography?

1091 Dr. Parekh. No.

1092 Mr. Schrader. Okay. All right. In rural Oregon, we have
1093 been able to make that happen. I am not talking to your situation,
1094 but just for the sake of the panel and others, there are ways
1095 to make APM systems work, ACOs work in rural settings. It is
1096 a culture, and after a while you figure out how to do it, like
1097 you all are doing as you adopt new practices and stuff.

1098 So, Dr. Ransohoff, you suggested maybe lowering the
1099 exclusion threshold in the MIPS program. Could you elaborate
1100 on that a little bit? To my investments, I mean, I would assume
1101 that the outcomes, whether you are a large practice or a small
1102 practice, the outcomes shouldn't really change. If it is
1103 patient-centered, you want the patient to be healthy, less

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1104 readmissions, less time between surgeries, whatever the option
1105 is. Could you talk a little bit about that?

1106 Dr. Ransohoff. Yes. I think that the main issue is just
1107 trying to get more doctors involved in the process. The way it
1108 is set up now, in a way what you have is you have a bunch of people
1109 who are believers, if you will, and are kind of going down that
1110 path, and then, you have a bunch of people who are just saying,
1111 "Thank goodness this doesn't affect me," and are not making any
1112 efforts to change.

1113 Mr. Schrader. Right.

1114 Dr. Ransohoff. I think that, in the absence of change, I
1115 don't understand how any of this gets to be affordable. And so,
1116 I do think there is going to have to be some change. By lowering
1117 the threshold from \$90,000 to some number less than that, you
1118 would start a gradual transition. People would know it was
1119 coming.

1120 I do think that, as my colleague here in solo practice points
1121 out, I think that this is doable. It is just that people don't
1122 want to do it.

1123 Mr. Schrader. So, maybe some sort of phase-in with the
1124 thresholds, so that people can see a path or eventually develop
1125 a path going forward?

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1126 Dr. Ransohoff. Correct.

1127 Mr. Schrader. So, the last question real quick, Dr. Barbe,
1128 everyone has pretty much referenced electronic medical records
1129 and EHR. I am very, very concerned that, while individual
1130 practices and groups are making huge investments -- originally,
1131 there was some money from the federal government to help out;
1132 gone now. Maybe that is something we should continue or think
1133 of strictly for small practices. But I am concerned about the
1134 systems -- and you guys have alluded to this -- not talking to
1135 one another. And there is a vested interest, with all due respect
1136 to our EHR developers, to keep that system pretty proprietary
1137 and pretty unique, so that you have got to buy their stuff. Could
1138 you talk a little bit about trying to broaden that out? Is there
1139 a role for the federal government to require some of these
1140 developers to make it easier for doctors to share their
1141 information across specialties, primary care, frankly,
1142 nutritionists, the whole gamut?

1143 Dr. Barbe. So, yes, we believe the Office of the National
1144 Coordinator can facilitate better interoperability. Many groups
1145 are trying workarounds now, all the way from health information
1146 exchanges to other cloud-based. Dr. Opelka earlier referenced
1147 activities of the American College of Surgeons. The AMA has

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1148 significant activities around an IHMI, or Integrated Health Model
1149 Initiative, that we believe has some great potential. But all
1150 of those are workarounds because the industry has not made data
1151 interoperable and, in fact, has blocked data in many cases.

1152 Mr. Schrader. Thank you. And my time is up, but I think
1153 that is a critical issue for this committee to address, if we
1154 are going to be successful going forward.

1155 Thank you very much, Mr. Chairman.

1156 Mr. Burgess. Thank you, Dr. Schrader.

1157 I would just point out that the third title in the Cures
1158 bill that we were planning on having oversight of the
1159 implementation was the electronic health records. We did have
1160 the mental health title evaluation earlier this week, I think,
1161 or was it last week? But, in any case, that has been held up
1162 because a rule has been stuck at the Office of Management and
1163 Budget, and we had initially planned to have that hearing in June
1164 and it was postponed because of that reason. Then, we are
1165 eventually just likely going to have to have the hearing without
1166 the rule having been finalized or released by OMB.

1167 I would now like to recognize the gentleman from Illinois,
1168 the chairman of the Subcommittee on Energy and Environment,
1169 Chairman Shimkus, 5 minutes.

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1170 Mr. Shimkus. Thank you, Mr. Chairman. This is a great
1171 hearing. Tough names out there. So, if I butcher them, I
1172 apologize for that.

1173 For Dr. Schrader, I think we do need to look at this as an
1174 exemption issue. If this is a movement forward, and there are
1175 cost challenges, we ought to get everybody onboard on the quality
1176 bandwagon.

1177 I can't remember who mentioned it in their opening statement,
1178 but someone, one of you mentioned that high-performers are not
1179 getting rewarded. Can you just address that a minute? Because,
1180 obviously, you mentioned, I think -- correct me if I am wrong
1181 -- poor-performers are being identified, but high-performers are
1182 not being rewarded.

1183 Dr. Rai. Yes, I think both Kurt and I mentioned that. At
1184 the end of the day, for the budget neutrality to work, there has
1185 to be just as many people involved in this. And that is what
1186 the exclusions created, was the incentive was cut in half for
1187 high-performers. Because there weren't as many people in there,
1188 the threshold was changed. So, from expecting a 4-percent to
1189 a 2-percent increase, yet making all the investments to value,
1190 is where we felt that high-performers were literally being
1191 penalized for making the right investments.

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1192 Mr. Shimkus. Any more? Dr. Ransohoff, I am going to go
1193 with you to the next question, too. So, why don't you answer
1194 that also?

1195 Dr. Ransohoff. Yes, we have the same issues. We spent
1196 probably half -- we will get a 2.02-percent reward for getting
1197 100 -- we probably spent half of that trying to get it. Now we
1198 had done that because we thought that the reward would be
1199 significantly more, and it is the right thing to do, but there
1200 is an economic issue with it.

1201 Mr. Shimkus. Yes, and I am going to talk economics a little
1202 bit, too. But I want to go back. What intrigued me about your
1203 comment to another question was, electronic health records or
1204 whatever, EMR, or whatever you want to call them, asking patients
1205 about indices that they may not be there for. We have been dealing
1206 with that with the opioid issue and trying to change law, so that
1207 there is a little more conversation. As you all know, there are
1208 catastrophic stories of the firewall between information, which
1209 has turned out deadly, and this whole committee has been trying
1210 to do things that we can do to address that. So, I applaud that,
1211 and hopefully, the legislation that we are moving forward,
1212 hopefully, with the Senate concurrence and a presidential
1213 signature, will start making that a little more available.

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1214 The concern is always going to be data privacy, personal
1215 privacy, and the like. So, you are the folks in the field and
1216 you are the ones who have to really help us see and help direct
1217 us on protection versus sharing of information throughout the
1218 practice. Especially if we are doing a patient center, as you
1219 guys were mentioning, holistic, with different people around,
1220 that information has to be shared throughout the practice. So,
1221 excellent point.

1222 I wanted to ask, I wanted to kind of go off, not totally
1223 off-script, and I am not trying to get this partisan or political,
1224 but in this current world today how much is, what are you paying
1225 -- how do you want to answer this question. I have always been
1226 worried about uncompensated care. Even with a government-run
1227 healthcare policy, high deductibles, can you talk to me about
1228 -- and that is all the time I am going to have. So, whoever wants
1229 to talk to me about, even in a system where we are doing Medicare
1230 and Medicaid, that doesn't pay costs, even if we are moving to
1231 high performance. So, if we are not paying the cost of care,
1232 and then, you have folks, and then, you are eating uncompensated
1233 care, that is where I think our system just breaks down. Anyone
1234 want to talk about uncompensated care or charity writeoffs, or
1235 however you want to define it?

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1236 Dr. Barbe. So, what the AMA would like to see is no
1237 uncompensated care not from our side, but because that means
1238 patients have coverage that will help them get access to care.

1239 That is the bottom line here. So, it is not a matter of how
1240 we handle uncompensated care. It is how do we get more people
1241 covered, so that they can have access?

1242 Mr. Shimkus. Quickly, anybody else want to jump in?
1243 Everybody else is compensated fully and there are no writeoffs?

1244 That is what you are saying? Or you just don't want to go into
1245 this debate right now?

1246 Dr. Opelka. Well, you have opened up a very complex subject
1247 matter.

1248 Mr. Shimkus. Yes, right.

1249 Dr. Opelka. The bottom line is that the uncompensated care
1250 patients, when they come in to seek surgical care, it is already
1251 too late. They are way behind the power curve. And that is the
1252 most unfortunate thing. We all see them. We all treat them.
1253 We take care of them.

1254 Mr. Shimkus. We should take care of them in the internist
1255 level or early intervention and provide that care --

1256 Dr. Opelka. Their cancers are diagnosed late. So, they
1257 have a poor outcome. Let's get in front of the disease, and the

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1258 uncompensated care patients come in a day late and a dollar short.

1259 Mr. Shimkus. My time has expired. Thank you, Mr. Chairman.

1260 Mr. Burgess. The Chair thanks the gentleman. The

1261 gentleman yields back.

1262 The Chair will recognize the gentlelady from California,

1263 Ms. Matsui, 5 minutes for questions, please.

1264 Ms. Matsui. Thank you, Mr. Chairman.

1265 And I thank the witnesses for being here today.

1266 We were talking about telehealth, and a group of us on the

1267 Energy and Commerce worked together to advance telehealth

1268 legislation, legislative and with the administration. As we have

1269 worked on legislative efforts, we have found CMS and CBO to be

1270 resistant to expanding access to telehealth due to cost concerns.

1271 Expansion has often been judged as adding a new service that

1272 could be overbilled, rather than taking into account that reducing

1273 hospital and ER visits would result in better care that could

1274 result from getting patients access to care sooner and more

1275 conveniently.

1276 I am encouraged that CMS has taken steps in this

1277 recently-proposed rule to expand access to telehealth in

1278 Medicare, as this is what we have been working toward. There

1279 will be no way to prove success in the Medicare population without

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1280 covering services. And I am curious to hear from our witnesses
1281 about the types of telehealth services that they currently
1282 implement.

1283 Starting with you, Dr. Barbe.

1284 Dr. Rai. I would be happy to start.

1285 Currently, in our organization we provide telestroke
1286 coverages to rural hospitals.

1287 Ms. Matsui. Okay.

1288 Dr. Rai. We also are opening up very small cities in
1289 Wisconsin, northern Wisconsin, so just Ladysmith at the new site,
1290 and we would love to provide more services to there. Some of
1291 our specialists live 5 to 6 hours from there --

1292 Ms. Matsui. Right.

1293 Dr. Rai. -- but easily could provide followup services
1294 or counseling services. There is not a lot of times in medical
1295 specialties especially, such as endocrinology, that we generally
1296 necessarily need to examine the patient. We need to be able to
1297 have that conversation and counsel that patient, or other services
1298 that are not even physician-based. But, unfortunately, we run
1299 into the wall with CMS and other payers without an ability to
1300 pay for that infrastructure, which does not come cheap. But we
1301 have done it with telestroke. We have done it. We have done

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1302 it very well. We hope to do more.

1303 Ms. Matsui. Okay. That is great.

1304 Anyone else want to comment on that?

1305 Dr. Barbe. So, there are many types of services and sites
1306 of services --

1307 Ms. Matsui. Right.

1308 Dr. Barbe. -- that are actually prohibited from
1309 participating in telehealth or digital medicine. We can start
1310 by getting rid of some of those restrictions. We can start by
1311 unbundling some of these payment codes, so that we can charge
1312 differently for consults versus remote patient monitoring.

1313 Ms. Matsui. Right.

1314 Dr. Barbe. My particular group is very robust in what we
1315 call virtual care, which is digital medicine, and we put
1316 monitoring devices in patients' home. We will even run the
1317 internet to their home, because in rural southern Missouri many
1318 don't have that. So, there are a lot of things, but we can't
1319 do this because there is no direct payment. The only reason we
1320 can do it now is we are in some risk-sharing arrangements.

1321 Ms. Matsui. All right. Anyone else here?

1322 Dr. Opelka. Just very quickly, where there are capitated
1323 environments, all these barriers to payment go away, and

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1324 telehealth actually becomes very creative and innovative. In
1325 a capitated environment, in my former practice we dealt with
1326 rural, like was mentioned, but we also dealt with prisoners, and
1327 putting telehealth in the prison became a very effective way of
1328 getting better care to the prisoner, rather than having to
1329 transport somebody with all kinds of guards and other security.
1330 Telehealth was a savior.

1331 Ms. Matsui. Okay. Let me just go on. One of my
1332 legislative efforts with Representative Bill Johnson on Energy
1333 and Commerce is H.R. 3482, which would remove originating site
1334 and geographic restrictions on telehealth in Medicare. And the
1335 steps CMS has taken to pay for virtual check-ins is very much
1336 in line with this idea. We passed a limited version of that bill
1337 for opioid service in the House opioids packages, and I hope the
1338 Senate will move to take this important legislation. And I really
1339 do look forward to having it expand further, and I think it would
1340 be helpful for all of you.

1341 I have been working to advance interoperability between
1342 electronic health records, and the proposed rule has implemented
1343 a performance measurement in order to promote interoperability.

1344 I guess, Dr. Opelka, you have talked about this. What success
1345 have providers had in working toward a goal of interoperability?

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1346 Do you feel that the implementation of MACRA has been helpful?

1347 Dr. Opelka. I don't know that MACRA itself has actually
1348 drawn attention to this. When we moved away from dealing with
1349 the EHRs and we created a patient cloud, and we began moving data
1350 into the cloud environment, in which we could represent
1351 information either to a patient or to a clinician from wherever
1352 that patient was seen, those models are now emerging separate
1353 from the EHR vendors. It is making a huge difference in care
1354 in those environments. That is the direction we need to go in,
1355 and that is where we need to actually educate the government to
1356 help us push incentives that drive us more to a patient cloud
1357 environment, rather than to say, this hospital, this EHR, it is
1358 this patient and all the hospitals they get care in.

1359 Ms. Matsui. Right. Okay.

1360 I think I have run out of time. I yield back. Thank you.

1361 Mr. Burgess. The Chair thanks the gentlelady. The
1362 gentlelady yields back.

1363 The Chair recognizes the gentleman from Ohio, Mr. Latta,
1364 5 minutes for questions, please.

1365 Mr. Latta. Thank you. Thank you, Mr. Chairman. I want
1366 to thank you for the hearing today.

1367 And I want to thank all of you for being with us today.

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1368 Because I am sitting here looking at you thinking to myself of
1369 all the patients you would be seeing right now in the time that
1370 you are taking to testify before us on this important matter.

1371 One of the great things that we get to do, we travel around
1372 in our districts. We talk to our docs back home. And we also
1373 have the ability to see a lot of the third-year, four-year medical
1374 students from our states come through. They are working on a
1375 lot of their specialties and everything else, but, at the same
1376 time, they kind of bring up with you all the sundry things that
1377 they are going to have to be doing to practice medicine.

1378 And I wonder if you all would mind answering a question for
1379 me, just going down the line, if you wouldn't mind. How much
1380 time do you take out, if you took a percentage, that you are
1381 practicing medicine or you are doing the administrative side of
1382 your job?

1383 Dr. Barbe. I can answer that very precisely. The AMA has
1384 done two studies. It shows that physicians spend about two hours
1385 in front of their computer screen or doing other paperwork for
1386 every hour they have in direct clinical contact. We did a second
1387 study that shows, for primary care physicians, they spent 60
1388 percent of their day in non-direct-patient-care activities.

1389 Dr. Opelka. And it is roughly about 20 percent of their

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1390 time doing administrative burden.

1391 Dr. Rai. It is ballpark around that same number. We at
1392 our own organization started to look at EMR utilization after
1393 5:00 or 6:00 p.m., when they log in from home after dinner, and
1394 how long they are on it. A significant amount of our primary
1395 care physicians are logging in late at night to complete their
1396 day, which is definitely leading to a nationwide situation with
1397 burnout.

1398 Dr. Parekh. I will echo the comments. I mentioned earlier
1399 my wife is an internist, and the kids go to bed around 9:00 p.m.
1400 and we get on our computers.

1401 Dr. Ransohoff. We have done the same kind of study. We
1402 see that internists, it varies somewhat by specialty, but in
1403 primary care it is not uncommon for doctors to spend 20 hours
1404 a week after hours doing documentation on the computer.

1405 Mr. Latta. And I know they are calling votes on us right
1406 here. I am going to ask just one question then. The clinical
1407 data registries and the certified EHRs that are envisioned by
1408 MACRA as serving as critical reporting mechanisms for providers
1409 to interact with the Medicare, would these represent a decrease
1410 in that administrative burden then? And just go down the line.

1411 Dr. Barbe. They haven't yet. The EHRs still just don't

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1412 work for physicians. There is too much point, click, move from
1413 one field to the next. Even in the certified technologies, which
1414 we have, we are still burdened significantly by that.

1415 Dr. Opelka. So, the clinical data registries, we run about
1416 seven international registries. They actually pull data in and
1417 generate knowledge, and that knowledge is delivered at the moment
1418 of care that allows for clinical decision support, that allows
1419 for better care, higher quality, et cetera. So, while they may
1420 take on time, they actually reduce burden and improve patient
1421 outcome. So, they are very welcome.

1422 Dr. Rai. I would echo that. The registries are welcome.
1423 They help us identify gaps in care that patients may need on
1424 an active basis, on a more timely basis, and the ability to access
1425 a patient to make sure that we get in front of them before they
1426 get in front of us in an acute situation.

1427 Dr. Parekh. As I mentioned in my testimony, the Academy
1428 of Ophthalmology created the IRIS, I-R-I-S, registry, and it has
1429 been a huge help. I will give you an example. Let's say, two
1430 days ago, I was doing surgery. My EMR records the date of the
1431 surgery on the right eye, for example. And then, when we see
1432 the patient back, of course, we record how the vision is doing.
1433 And one of our measures is, is the patient 24/40 or better within

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1434 90 days? So, it is an outcome measure, like I said, very important
1435 to our speciality, very important to our patients. And so, as
1436 soon as that vision reaches that threshold, the EMR automatically
1437 captures that data. The point is, we are getting outcomes data
1438 and it is very little additional work because the registry is
1439 able to grab that info without me typing it in again for the
1440 registry. So, it has been great.

1441 Dr. Ransohoff. There is nothing faster than ineligible
1442 handwriting that is not shared with anyone.

1443 [Laughter.]

1444 And I practiced in those days. The computer systems that
1445 are out there now are more time-consuming. I do think they are
1446 much better.

1447 I prescribed recently -- the patient was on two unusual
1448 medications, and they computer said there is going to be a drug
1449 interaction. And so, there are real benefits to it, but it is
1450 definitely more time-consuming.

1451 Mr. Latta. Okay. Well, Mr. Chairman, my time has expired,
1452 and I yield back.

1453 And I thank our witnesses again for spending time with us
1454 today. Thank you.

1455 Mr. Burgess. The gentleman yields back. The Chair thanks

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1456 the gentleman.

1457 The Chair does acknowledge there is nothing faster than bad
1458 handwriting, particularly if you are lefthanded.

1459 The Chair now recognizes the gentlelady from California,
1460 Ms. Eshoo, 5 minutes for questions, please.

1461 Ms. Eshoo. Thank you, Mr. Chairman.

1462 And thank you to the witnesses. You represent so many that
1463 practice medicine across our country in the different
1464 disciplines, and have headed up, and do head up, organizations
1465 that are representing them.

1466 I would like to go to Dr. Rai and Dr. Ransohoff with this
1467 question. Earlier this month, CMS released a proposed rule that
1468 estimated that 42 percent of physicians participating in Medicare
1469 will need to comply with MACRA. So, my question to both of you
1470 is, with so many physicians that are exempt from both APMS and
1471 MIPS, has CMS undermined the original intent of MACRA? Would
1472 that be your take? And with so many physicians exempt, will MACRA
1473 meet the original payment reform goals it set out to achieve?

1474 Dr. Rai. I do believe CMS has gone against the intent of
1475 MACRA with the exemptions. For this to work, for us to truly
1476 move to value, the intent of MIPS, as one of my colleagues has
1477 been quoted to say, MIPS was the on-ramp to value and CMS has

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1478 created an exit ramp.

1479 Ms. Eshoo. Why do you think they are doing this?

1480 Dr. Rai. I think because the move -- change is never easy.

1481 The change of going from fee-for-service to value, to taking

1482 risks --

1483 Ms. Eshoo. Oh, we have been doing that for a long time.

1484 This isn't exactly something that happened in the last 90 days.

1485 I mean, we have been in transition since I first came into the

1486 Congress on this thing, and I have been here for a while.

1487 Dr. Rai. I don't disagree with you at all. The legacy

1488 programs did not have the exemptions. And now, all of a sudden,

1489 we are exempting people, and it is truly preventing -- it is

1490 another kick-the-can-down-the-road. It is becoming SGR 2.0 if

1491 they continue that behavior.

1492 Ms. Eshoo. Well, how do you think CMS can improve the MIPS

1493 implementation?

1494 Dr. Rai. Implement it as it was written. I mean, really

1495 implement what you passed.

1496 Ms. Eshoo. Great. Good answer. Good. All right. Well,

1497 that is confidence in the work that we have done, Mr. Chairman.

1498 To Dr. Opelka and Dr. Parekh -- is it "Parak" or "Paresh"?

1499 Dr. Parekh. Parekh.

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1500 Ms. Eshoo. Parekh.

1501 I have heard from physicians in my congressional district
1502 -- it is the Silicon Valley district in California -- that those
1503 in small practice and who practice specialty care face barriers
1504 in participating in MIPS. Do you face barriers, as some of my
1505 physicians have reported? And if so, what are they?

1506 Dr. Parekh. Thank you for the question.

1507 As an ophthalmologist, again, I feel very lucky. We have
1508 amazing professional societies. We have been working for a long
1509 time, as you said, coming up with measures. I mean, we have been
1510 preparing for this moment for a while, coming up with outcomes
1511 measures, coming up with process measures, creating cost
1512 measures, having a registry. So, I am very fortunate -- knock
1513 on wood; I thank our professional societies -- it hasn't been
1514 that hard for us in ophthalmology.

1515 Ms. Eshoo. Well, that is good. Do you know Dr. Chang?

1516 Dr. Parekh. Dr. David Chang.

1517 Ms. Eshoo. Dr. David Chang, yes.

1518 Dr. Parekh. Yes, he is one of my very good friends. In
1519 fact, he knew that I was coming today and sent me a very kind
1520 email.

1521 In ophthalmology, I think our numbers to some extent back

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1522 up what I am saying. I think people who participated in our
1523 registry, I think 85 percent got a score of 100, getting the 2
1524 percent that was mentioned earlier, and I think 99 percent got
1525 some type of bonus. So, again, we have been working hard at this,
1526 very hard at this, and I think it is blossoming.

1527 Ms. Eshoo. Would you recommend anything to us that would
1528 lessen the burden on physicians, so that you can more actively
1529 participate in MIPS or do you think it is just working swimmingly?

1530 Dr. Parekh. I think there is always room for improvement.

1531 Ms. Eshoo. Always, yes.

1532 Dr. Parekh. Like I said, it is a continuous quality
1533 improvement mindset that we have to have.

1534 Ms. Eshoo. But do you have something, anything specific?
1535 Anyone have anything specific?

1536 Dr. Opelka. Sure. So, this whole matter of participating
1537 or exclusions, if you don't measure what matters, putting money
1538 and investments into something that is senseless, nobody wants
1539 to participate.

1540 Ms. Eshoo. And that is what we are doing?

1541 Dr. Opelka. So, all the surgical specialties, all of them,
1542 including ophthalmology, the majority of their measures have
1543 nothing to do with surgical care.

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1544 Ms. Eshoo. Wow.

1545 Dr. Opelka. They are measuring primary care. So, it
1546 doesn't surprise me that primary care says everyone should be
1547 in, but it also doesn't surprise me when surgery care says, "It
1548 doesn't matter to the patients I am treating. So, why am I
1549 spending money in my practice to send CMS tobacco cessation and
1550 immunization rates?" Nobody comes to me as a surgeon with breast
1551 cancer to talk about those things. We are not measuring what
1552 matters. And so, as long as we are going to measure silly things,
1553 everyone is going to say, "I want to be excluded." If you want
1554 to measure what matters, put me in. Put me in, coach. I want
1555 to play. But that is not what we are getting.

1556 Ms. Eshoo. Well, I think that that is highly instructive
1557 to us, Mr. Chairman.

1558 Mr. Burgess. That is the reason we are having the hearing.

1559 Ms. Eshoo. Yes. Well, that is what happens in hearings.

1560 Mr. Burgess. And I appreciate your --

1561 Ms. Eshoo. But what I am suggesting is that we work with
1562 CMS to get rid of what was just described as the -- did you use
1563 the word "silliness"?

1564 Dr. Opelka. Yes.

1565 Ms. Eshoo. Okay. Thank you to all of you. I mean, you

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1566 are the healers of the nation. So, thank you for what you have
1567 devoted yourselves to, and taking on the extra responsibility
1568 of heading up organizations.

1569 Mr. Burgess. If the gentlelady will conclude her soliloquy

1570 --

1571 Ms. Eshoo. Thank you.

1572 Mr. Burgess. -- we have about a minute left on a vote on
1573 the Floor.

1574 Ms. Eshoo. I yield back.

1575 Mr. Burgess. I am going to recess after I acknowledge the
1576 presence of Dr. Boustany, former Member of Congress and member
1577 of the Ways and Means Committee. We appreciate your attendance
1578 here today.

1579 And we will stand in recess until after this vote.

1580 [Recess.]

1581 Mr. Guthrie. [presiding] The committee will come back to
1582 order. Thank you.

1583 There will be other members that are voting and will be back
1584 shortly to ask questions, but we are going to continue the question
1585 period.

1586 All right. The Chair recognizes Dr. Bucshon for 5 minutes
1587 to ask questions.

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1588 Mr. Bucshon. Thank you, Mr. Chairman. I appreciate that.

1589 And thank you to all the witnesses for being here. I was
1590 a cardiothoracic surgeon before coming to Congress, and this is
1591 critically important for our patients at the end of the day, right?

1592 And that is what I try to focus on.

1593 As you know, the participation in MIPS is low. Everyone
1594 outlined roughly 60 percent of physicians are excluded from the
1595 program, leaving only \$118 million of the \$70 billion baseline
1596 for incentive payments for practices. Participation in the
1597 alternative payment models in MACRA is even smaller, with only
1598 5 percent of physicians enrolled in an APM. CMMI has not approved
1599 a single APM submitted from PTAC, and PTAC cancelled its June
1600 meeting due to lack of APMS to review.

1601 I am interested in ways to increase participation in and
1602 the number of APMS, which is why I introduced the Medicare Care
1603 Coordination Improvement Act, H.R. 4206, which three of you on
1604 the panel's organizations have signed a letter in support of --
1605 and I will get to that in a minute -- which would encourage
1606 development, testing of participation in APMS by exempting
1607 practices from the volume and value prohibitions in the Stark
1608 law. After all, how can practices deliver on value-based care
1609 if they cannot remunerate their physicians based on value?

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1610 Mr. Chairman, I ask unanimous consent to submit the letter
1611 to the record.

1612 Mr. Guthrie. Without objection, so ordered.

1613 [The information follows:]

1614

1615 ***** COMMITTEE INSERT 6*****

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1616 Mr. Bucshon. The American College of Surgeons, the American
1617 Medical Association, and AMGA, amongst many others, have signed
1618 onto the letter.

1619 Basically, it says they are in strong support of the act
1620 that we introduced and "The legislation would substantially
1621 improve care, coordination for patients, improve health outcomes,
1622 and restrain costs by allowing physicians to participate and
1623 succeed in alternative payment models." The bill would modernize
1624 the Stark self-referral law enacted nearly 30 years ago.

1625 The things that it would do is provide HHS with the same
1626 authority to waive the prohibitions of the Stark law and
1627 associated fraud and abuse laws for physicians seeking to develop
1628 and operate APMs, as was provided for ACOs in the Affordable Care
1629 Act; remove the volume or value prohibition in the Stark law,
1630 so that physician practices can incentivize physicians to abide
1631 by best practices and succeed in the new value-based alternative
1632 payment models. This protection would apply to physician
1633 practices that are developing or operating an alternative payment
1634 model, including the advanced APMs, APMs approved by the
1635 physician-focused payment model, the Technical Advisory
1636 Committee, MIPS APMs and other APMs specified by the Secretary;
1637 and finally, ensure that CMS's use of current administrative

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1638 authority promotes care coordination, quality improvement, and
1639 resource conservation.

1640 I guess I will ask the question of everyone. How do you
1641 think changes to the Stark law would help physicians coordinate
1642 and improve care and help MACRA succeed? And how important do
1643 you think that would be in the overall success of what we are
1644 trying to do with the MACRA legislation and, also, as you have
1645 noted, transition to an outcome-based, patient-centered-based
1646 way to reimburse providers?

1647 I will just start that. If any of you aren't aware of what
1648 we have done, that is okay. But we can start with the surgeons.

1649 Dr. Opelka. Thank you very much.

1650 First of all, yes, we are in strong support of this effort.
1651 Specifically, the way that Stark is written, you can be held
1652 accountable without intent, and that is a problem. So, when we
1653 have alternative payment models with shared savings opportunities
1654 between all the parties, legal counsel, when they review these
1655 contracts, become extremely worried about how clean are these
1656 waivers or exemptions from Stark. They have got to be bulletproof
1657 because Stark is so broad and overreaching, it is easy for a court
1658 to interpret things different than your own counsel interpreted
1659 them.

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1660 For that reason, when we go to these alternative payment
1661 models where there are parties that will be involved in shared
1662 savings, or whatever different payment models are applied, we
1663 need to be sure that there is clean, crisp lines that exempt or
1664 waivers that are provided for Stark, so the parties can come
1665 together. That is really what we see. When we put our own APM
1666 forward to PTAC, we included the need for Stark waivers and the
1667 exemptions. But we agree with you and fully support what you
1668 are doing.

1669 Dr. Ransohoff. In order to have an ACO, particularly an
1670 ACO like this that requires risk-taking and risk-sharing, you
1671 need to get a group of physicians together who are willing to
1672 work together and share the risk and, also, generally, a hospital.

1673 So, you need all of those parties to do that. Then, these laws
1674 become a serious impediment to doing that. Just the legal
1675 expenses of trying to make sure it is even okay to have a meeting
1676 become daunting. So, I think if you are going to encourage
1677 doctors and hospitals to try to take risks together in a
1678 fee-for-service world, you do need to look at the regulatory
1679 barriers that exist.

1680 Mr. Bucshon. All right. Thank you.

1681 Beg your indulgence, Mr. Chairman.

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1682 Anyone else have any comments quickly? Anyone else? Yes?

1683 Dr. Rai. Stark made sense in a fee-for-service environment,
1684 but if we are truly going to move to value, we need regulatory
1685 relief, as explained by my colleagues.

1686 Mr. Bucshon. Okay. Thank you. I appreciate that.

1687 Thanks, Mr. Chairman. I yield back.

1688 Mr. Guthrie. Thank you. The gentleman yields back.

1689 The Chair now recognizes Mr. Griffith of Virginia, 5 minutes
1690 for questions.

1691 Mr. Griffith. Thank you very much, Mr. Chairman. I
1692 appreciate it.

1693 I appreciate you all being here. With two votes series
1694 disrupting the committee, it is tough as witnesses, and I do
1695 appreciate your patience.

1696 Let me echo what my colleague just said about the Stark Act.

1697 I think it is outdated probably in more ways than most people
1698 do. And I find it inhibits some collaboration in rural areas
1699 where we are underserved already. And why would we put barriers
1700 up?

1701 Does anybody disagree with that statement? I am looking
1702 at the entire panel. Just for the record, none of them disagrees
1703 with that statement.

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1704 All right. Let's see. Given that, now I have got a question
1705 that we want to get on the record. On June 29th, CMS allowed
1706 MIPS participants to see their performance score based on 2017
1707 reporting. Would each of you please share what your scores were?

1708 Dr. Rai. I would be happy to start since I brought mine
1709 with me.

1710 Mr. Griffith. All right. That would be fine.

1711 Dr. Rai. We bill under four Tax ID Numbers because of how
1712 we are regionally divided. Three, we scored 100, and on the
1713 fourth one we had a 97.

1714 Mr. Griffith. Okay. Anybody else weigh-in who knows?
1715 Yes, sir?

1716 Dr. Parekh. I like your question because it also relates
1717 to the previous issue of physician participation. I was in a
1718 big group practice and I decided to start my own practice. And
1719 so, it was the end of 2015 and into 2016 that I was doing that.

1720 The 2017 measurement, what you are asking about, is based on
1721 your surgical volume or your volume at the end of 2016, but that
1722 is when I was starting my practice.

1723 I knew, of course, about our Academy's IRIS registry. I
1724 knew myself. I knew that I could do a good job on those measures,
1725 but there was no opportunity for me to participate. I couldn't

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1726 opt-in. I couldn't believe that I couldn't opt-in. So, I asked
1727 multiple people. I am like, "Are you sure I can't opt-in? I
1728 would love to do this. This is great. That is a good measure."

1729 Multiple people assured me I could not.

1730 Mr. Griffith. Okay.

1731 Dr. Parekh. So, unfortunately, I was not eligible, even
1732 though I wanted to be.

1733 Mr. Griffith. All right.

1734 Dr. Ransohoff. As I have said before, we bill under a single
1735 Tax ID Number, and we did get 100.

1736 Mr. Griffith. Okay. And last, but not least.

1737 Dr. Opelka. I am retired from practice.

1738 Mr. Griffith. Yes? So, no data? All right. I appreciate
1739 that. Thank you so much.

1740 My concern, of course, is rural areas, as I mentioned before,
1741 when I was talking about the Stark Act. So, when we are looking
1742 at rural areas, can you describe or can any of you illuminate
1743 us on the challenges of physicians practicing in the rural areas
1744 and the pressures they face to remain in practice? And how do
1745 the legacy programs add to those burdens? I mean, I know a lot
1746 of the burdens they have already. But how do the legacy programs
1747 add to those burdens, and has MIPS eased those burdens? And even

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1748 if it has eased them a little bit, what else can we be doing to
1749 help our rural friends?

1750 Dr. Barbe?

1751 Dr. Barbe. Maybe I will weigh-in on that first. So, I was
1752 amazed when MACRA passed and we were looking at MIPS, and we had
1753 a lot of physicians come out of the woodwork and say, "Oh, my
1754 gosh, how are we going to comply with MIPS?" And I thought in
1755 my mind, well, have they not been doing the legacy programs
1756 already? And the answer is, no, they hadn't. Hundreds of
1757 thousands of physicians didn't participate in all three or didn't
1758 participate successfully. So, there are a lot of physicians that
1759 are now working to make this transition.

1760 Specifically, with regard to rural, Dr. Opelka said it very
1761 well. We need meaningful measures that relate to that individual
1762 physician's practice. We need to make them easy to capture, and
1763 we need to make them, if you will, activities that are applicable
1764 across more than one of those dimensions of MIPS. If you have
1765 got a diabetic patient and you are changing your processes and
1766 you are improving care, and you are using an electric record,
1767 why don't you get credit across all three domains?

1768 Mr. Griffith. All right. Yes, sir?

1769 Dr. Opelka. Very quickly, the trauma program is a classic

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1770 example where we have Level I, II, and III levels of service.

1771 Typically, in the rural environment we are dealing with a Level

1772 III. The number of standards they need to meet are significantly

1773 less than the 200-plus standards for a Level I. So, you need

1774 to tailor measurement down to the point of care and the care model

1775 that that environment has. The MIPS program does not do that.

1776 It is a one-size-fits-all program. So, the rural element is

1777 no different than, in surgery, it is no different than in the

1778 city. They are not meaningful and fit for purpose. And

1779 therefore, the surgeons pay attention to it for purposes of

1780 payment, but not for the purposes of quality of care.

1781 Mr. Griffith. Okay. Anybody else? Yes?

1782 Dr. Rai. We operate many rural clinics, but because they

1783 are part of a larger multi-specialty group, we are able to spread

1784 our infrastructure more efficiently to them.

1785 And to your other question about was it easier under MACRA

1786 to submit versus the legacy programs, I have talked to our quality

1787 department. It was slightly easier this year to submit to CMS.

1788 The mechanism of submitting all three at once was easier than

1789 the previous legacy format.

1790 Mr. Griffith. So, it was a little bit better?

1791 Dr. Rai. A little bit better, yes, sir.

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1792 Dr. Parekh. I would echo all these comments. Understand
1793 that rural medicine is very different than urban/suburban. And
1794 I know in Washington oftentimes people talk about a bubble in
1795 Washington, but coming from central Pennsylvania, it is a very
1796 different environment here. I mean, let me tell you, there are
1797 hospitals where I can't get internet service. I mean, just think
1798 about that statement. And my EMR, of course, is a cloud-based
1799 EMR. I mean, this is a true issue. But, again, I think MACRA
1800 has certainly helped, to answer the second part of your question.

1801 Mr. Griffith. Other parts of our committee are trying to
1802 work on those internet issues.

1803 Dr. Ransohoff?

1804 Dr. Ransohoff. I mean, technically, right now for someone
1805 who had just done nothing, MIPS is actually better, just by the
1806 algebra of it initially, because the cut would have been less.

1807 But I agree with my colleagues, and I have said previously
1808 I think for small practices in rural areas they just need a
1809 different -- they need relevant standards that resonate with their
1810 practice, but they probably need to have a different test, so
1811 that they can participate. Fewer measures I think would be a
1812 very reasonable approach.

1813 Mr. Griffith. All right. Thank you very much. I

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1814 appreciate it.

1815 And my time is up and I yield back.

1816 Mr. Guthrie. Thank you. The gentleman yields back.

1817 The Chair now recognizes Mr. Carter from Georgia for 5
1818 minutes for questions.

1819 Mr. Carter. Thank you, Mr. Chairman.

1820 And thank all of you for being here.

1821 Before I begin my questions, I have to say this. Earlier
1822 in the hearing there was a conversation about doctors'
1823 handwriting. And I just want to say, I want to represent my
1824 profession as a practicing pharmacist for over 30 years. So,
1825 you get it? You understand what I am saying.

1826 [Laughter.]

1827 Anyway, I couldn't resist that and I apologize. Too many
1828 times have I struggled to understand what a doctor was writing.

1829 I wanted to talk to Dr. Rai. Okay, I am sorry. I know I
1830 butchered that.

1831 But, nevertheless, as a pharmacist, I am a member of the
1832 Doctors Caucus. We had sent a letter to CMS earlier this month
1833 about MACRA and MIPS implementation and the \$500 million that
1834 had been authorized to ensure positive payment adjustments. But
1835 one of the things that we have run into is that we just don't

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1836 have enough physicians who are participating. And I just wanted
1837 to ask you. CMS estimates that it is over 60 percent that aren't
1838 participating. What are the obstacles? What are some of the
1839 obstacles that are preventing or prohibiting providers from
1840 switching to this?

1841 Dr. Rai. I think some of the obstacles are inherent to how
1842 they have been practicing medicine and how their own structures
1843 have been developed over time. Some may say they have not
1844 followed the legacy programs, as was mentioned earlier. So, they
1845 have not actually implemented the EMR or using it in a meaningful
1846 way. They have not developed patient-centered medical homes or
1847 have the ability to tap into registries. There are a variety
1848 of reasons why people are not participating.

1849 But for us to truly move to value, we need everybody to
1850 participate. MACRA was written to be a carrot-and-a-stick
1851 program. So, for it to work, everybody has to be in.

1852 Mr. Carter. I suspect that I would be correct to say that
1853 it is worse in rural areas than it is in urban areas. Is that
1854 correct?

1855 Dr. Rai. I haven't seen CMS's distribution of who is not
1856 participating, but I think it is across the board. I think you
1857 will see it in small single specialty in a very urban area. But,

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1858 yes, you will probably see it a lot in urban areas that don't
1859 have a system infrastructure supporting them.

1860 Mr. Carter. Okay. Can you describe very briefly about some
1861 of the investments that your organization has made in order to
1862 participate in this?

1863 Dr. Rai. I can break the investments into three categories,
1864 the first being people. The most important category in
1865 healthcare is continuously investing in people. Team-based care
1866 is not inexpensive -- nurse care managers, extra medical
1867 assistance, making sure the physician or the provider is
1868 surrounded by the best people to take care of their population,
1869 not just the patient that is in front of them that day.

1870 The next area is, like I mentioned, an EMR is only as good
1871 as you can draw the data out of. So, our largest area of
1872 investment in the EMR is not really the EMR anymore. It is digital
1873 platforms to draw the data out, to analyze it, to hopefully someday
1874 get access to claims data, which we need, to be able to look at
1875 a risk population and predict what is going to happen to a patient
1876 before it happens to them.

1877 And the third area of investment is that digital platform
1878 that is patient-facing. Our patients want access to their
1879 record. It is not our medical record; it is their medical record.

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1880 It is creating environments for them to interact with us in
1881 virtual care, like we launched this year, where they don't have
1882 to come into the office.

1883 Those have been the three categories of investments that
1884 we personally made to make sure we are successful not only with
1885 MACRA, but with value down the line.

1886 Mr. Carter. Right. Thank you.

1887 Dr. Parekh, I wanted to ask you, in your testimony you had
1888 mentioned that MedPAC had made the recommendation that MIPS should
1889 be replaced with a voluntary value program that might be phased
1890 in over time. And I just wanted to ask you -- and in full
1891 disclosure, I agree with you; I don't agree with MedPAC. I think
1892 that would be the wrong route for us to go. I think we are headed
1893 in the right direction with this. We ought to figure out a way,
1894 I think, if not to incentivize, then to require physicians to
1895 do this. And I don't like that. I don't like the heavy-handed
1896 government, particularly in healthcare. But, at the same time,
1897 I am convinced we are moving in the right direction.

1898 I just wanted to ask you, what are some of the challenges
1899 to developing outcome measures in the practice of medicine?

1900 Dr. Parekh. It is just hard. It is hard to do. You have
1901 to have a clean measurement. You don't want all these other

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1902 comorbidities that are, quote/unquote, "messaging up your
1903 outcomes". So, let's take cataract surgery, for example. If
1904 I have a patient who has got severe blinding macular degeneration
1905 at baseline, and then, they have developed a cataract on top of
1906 that, as bad as it originally was, now it is worse. So, I take
1907 their cataract out and I get them maybe to 2400, which is the
1908 big "E", legal blindness still. They are ecstatic, but my measure
1909 might look bad because, "Oh, Dr. Parekh, this patient, you
1910 operated on them and they are legally blind." So, things like
1911 that, those subtleties, the devil is in the details.

1912 Mr. Carter. Right.

1913 Dr. Parekh. Those subtleties make all the difference. So,
1914 coming up with those kind of clean outcomes is very hard to do.

1915 Mr. Carter. Right.

1916 Dr. Parekh. And so, there are certain surgeries that lend
1917 themselves to that, but others that don't.

1918 Mr. Carter. I am out of time. But I want to thank all of
1919 you for your efforts in moving this forward, because I do believe
1920 it is we are headed in the right direction with this.

1921 And I yield back.

1922 Mr. Guthrie. Thank you. The gentleman yields back.

1923 Seeing there are no further members wishing to ask questions,

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1924 I would like to thank you all for being here today. As somebody
1925 mentioned earlier, you are missing a lot of patients today to
1926 be here to inform us, but it is important that you do.

1927 And I would like to submit the following documents for the
1928 record: American Academy of Dermatology Association, letters
1929 from the American Academy of Family Physicians, the American
1930 College of Physicians, Connected Health, American Society of
1931 Clinical Oncology, Infectious Disease Society of America, and
1932 Medical Group Management Association.

1933 Mr. Green. No objection, Mr. Chairman.

1934 Mr. Guthrie. Without objection, so ordered.

1935 [The information follows:]

1936

1937 ***** COMMITTEE INSERT 7*****

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1938 Mr. Guthrie. Pursuant to committee rules, I remind members
1939 that they have 10 business days to submit additional questions
1940 for the record, and I ask that witnesses submit their response
1941 within 10 business days of receipt of the questions.

1942 Without objection. Mr. Green. Mr. Chairman, I would just
1943 like to recognize a family from my district, the Garcia family.
1944 We spend a whole lot of time in these committee meetings. But
1945 I thank them for coming here.

1946 Mr. Guthrie. Welcome. Welcome to Washington. Thanks for
1947 being here.

1948 So, without objection, the subcommittee is adjourned.

1949 [Whereupon, at 12:13 p.m., the subcommittee was adjourned.]

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