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

My group, Sansum Clinic, has been on a journey, going from the previous sustainable growth rate (SGR) payment system, to becoming a devoted MIPS provider under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), to becoming a Track One Plus Accountable Care Organization (ACO), all over a period of several years. Our journey will provide some insight into what is good and what is less good about the recent shifting of the tectonic plates on which the Medicare physician payment system stands.

Before going further, let me tell you about me and my group. I am a general internist. I went to UCLA Medical School and then did my internship, residency, and chief residency at UCLA. I was on the faculty there for a few years after finishing my training, before moving to Sansum Clinic in Santa Barbara as a general internist 26 years ago. I've continued to practice in the same exam rooms for the last 26 years. I've been doing this long enough to recall hand-writing my patient progress notes and to have cared for multiple generations of family members. I have been able to say to a 70-year-old man – "Your heart murmur sounds just like your dad's at your age." I've been honored to practice for that long of a time in the same setting.

Sansum Clinic is a nearly 100-year-old not-for-profit Medical Foundation. It is an oddity in that it is not affiliated with a hospital. We have about 200 doctors and care for about 125,000 patients each year. We have almost all of the different specialties. Over the last 40 years, we have been involved in capitated HMOs, Fee For Service (FFS) models, POS plans, PPOs, ACOs, and the whole alphabet soup of modern health insurance. That is important because we have been comfortable with the many different models and can appreciate the advantages and disadvantages of each.

For the last two years, I have been the Board Chair of America's Physician Groups (APG). APG is a professional association representing more than 300 of the most advanced medical groups in the country. All are involved in integrated and coordinated care, with most taking risk to various degrees. Our tag line "Taking Responsibility for America's Health" is truly what our groups do. We all take clinical responsibility for America's health. Many take complete financial responsibility too.

With that background, l will return to the story of our journey from the SGR days to being a Track One Plus ACO.

Whatever criticisms there are about MIPS and MACRA, almost all doctors will say "Thank You!" to Congress for doing away with the flawed SGR process. In the SGR days, our budgeting process would begin with trying to manage the double-digit decrease called for by the SGR formula. It would make it impossible to balance our budget. The implementation of the cut would mean insolvency, so we would explain to our Board that we were going to ignore the projection and assume a flat payment from Medicare or a one percent increase. Board members would understandably think it was crazy to do this the first time they heard about this

process. Then they would get used to the annual chaos of ignoring what was published. We all sighed a great sigh of relief when the SGR was repealed.

There was then this new process, MACRA, on the scene. It was a bit of a mystery at first. There was a wonderful slide APG had created that showed a doctor standing at a fork in the road, with one fork indicating the MIPS road and the other Advanced Alternative Payment Model (AAPM) road. That was how we all saw it. Everyone had to choose, either you go down the MIPS road or the AAPM road. There was no rest area in the slide. There was no parking lot in which someone could just wait until a different road was built, or just settle in the parking lot and never move on.

That is important. At the outset, the idea was that almost everyone would be in MIPS or an AAPM. The idea was to move everyone from volume to value. As a provider you had to choose one of the roads. So, we chose to be a MIPS provider. I was a zealous supporter of MIPS. I participated in panels explaining why MIPS was a good choice for many groups, including ours. And yet, as I said, we ultimately wound up being a Track One Plus ACO. What happened?

We believed MIPS would be as presented. Most would participate. Those who moved strongly in the value direction would be rewarded as outlined, with at least a four percent bonus for high-scoring groups in the initial 2017 performance year. The bonus would increase in later years. There would be a large pool of money that would fund high-scoring groups, with the funding provided by groups that did not move in the value direction.

Due to multiple factors in the implementation process, that is not how it played out. Many were exempted. The initial year became a transition year, with the ability to meet a neutral adjustment with minimal effort. Then there were lots of exclusions. There were rural

exclusions, small group exclusions, exclusions related to hurricanes and weather events (whether or not the physician was indeed affected by said event). The most powerful exclusion was based on the low volume threshold, under which one was exempt from MIPS. It went from $30,000 and 100 patients, which, according to the Federal Register, would have exempted 380,000 providers to $90,000 or 200 patients, exempting more than 540,000 providers. We fully recognize exemptions are necessary in some cases, but this level of exemptions undermines the spirit of the law.

We had assumed it was going to be a standardized test, like the SAT, which most everyone would take and would be graded on the curve. Instead, it became an SAT test, still graded on the curve, but with only Advanced Placement students taking it. Many were simply told “You don’t need to worry about that test; it is not for you.”

We studied hard and tried to do well at MIPS. Much of it entailed starting new systems to be sure we captured missing gaps in care and made sure that all rowed in the direction of value. We made significant financial investments in that. We scored 100 on MIPS. We recently found out our adjustment would be 2.02 percent not the four percent or more that was advertised. This is still meaningful, but the costs of doing well are considerable, and the reduction of incremental payment reduced our margin significantly.

Given these factors, we decided that we needed to get off the MIPS road and get onto the AAPM road. We looked and felt that the Track One Plus ACO was the best choice for us. It gives us an exemption from the unpredictability in MIPS and gives us the chance to earn a five percent increase in our Medicare reimbursement. We are now working with our local hospital in managing our Fee-For-Service Medicare population. That is allowing us to do things that will

improve the health of that population in ways that we would not otherwise have been able to do. But it is important to note, despite its flaws, many of the skills we learned during our MIPS phase are still valuable and still important.

What have we learned?

- The way MIPS has been implemented has not been the way it was planned. A large fraction of doctors is exempt. The few left in MIPS will, on the whole, do very well in their scores, but achieve very little in return, even if they have done everything well that the legislation encouraged them to do. It is now an asymmetric process; the intended large reward for high-scorers is gone, but the intended large loss for those who score poorly is still there.
- The clinical benefits are real in terms of care itself and the care processes that are created to achieve the goals of the program. Those processes can be infrastructure intensive and to participate fully in MIPS is complex and not practical for a small group.
- There are a number of AAPM models, allowing groups to leave MIPS and move more in the direction of population management. That is good, though ironically it worsens the MIPS problem.
- There has been a recent acknowledgment that CMS should look outside of the FFS Medicare world for models that can be used to encourage the movement from volume to value. The recently proposed Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration is an example of that.

Here are some suggestions that can encourage the movement from volume to value.

- Lower the threshold for excluding groups entirely from MIPS, and thereby increase the number of physicians participating in MIPS. At the same time, in recognition of the fact that smaller groups have fewer resources, MIPS for smaller groups may need to look different from MIPS for larger groups. In other words, give smaller groups a different test, more suitable for their resources, instead of excluding them entirely. Doing so will help move more doctors from volume to value and allow more to participate, while acknowledging that smaller groups have more limited resources to comply with an overly burdensome test.
- Look at other models that will allow groups of doctors that are willing to embrace risk-taking and high value care to do that. APG has a model, known as the "Third Option" that does just that.
- Continue to look at care models outside of traditional FFS Medicare, most notably capitation, in which groups assume financial risk and responsibility. The care given in that model, when the activities of doctors are measured, should count towards the value-based care Congress is trying to promote.
- Even if there are flaws in MIPS, there is value for individual patients and populations of patients and, importantly, the payer for all of this – the American taxpayer – in encouraging data collection and reporting and promoting high-quality and high-value care. The processes that are created to do that will help move Medicare from volume to value. We should find ways of making it feasible for more providers to participate in that process instead of excluding them. Encouraging participation in a manner that is sensitive to a group's resources will create more providers with the competencies and

ability to know the needs of their patient populations, to better address those needs, to more wisely deploy financial resources, to produce better outcomes, and to better coordinate the care of seniors that sorely need that coordination.

Thank you for allowing me to speak with you this morning. I will be happy to answer questions.

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