THE IMPLEMENTATION OF THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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THE IMPLEMENTATION OF THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

WEDNESDAY, MAY 11, 2016

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 2:05 p.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Wednesday, May 4, 2016
No. HL–07

CONTACT: (202) 225–3943

Chairman Tiberi Announces Health Subcommittee Hearing on the Implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

House Ways and Means Health Subcommittee Chairman Pat Tiberi (R–OH) today announced that the Subcommittee will hold a hearing entitled "The Implementation of the *Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)*." **The hearing will take place on Wednesday, May 11, 2016, in Room 1100 of the Longworth House Office Building, beginning at 2:00 p.m.**

Oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, May 25, 2016**. For questions, or if you encounter technical problems, please call (202) 225–3943 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman TIBERI. The Subcommittee will come to order. Good afternoon everybody. So we are going to begin. I am really excited to finally be having this hearing.

When I came to Congress back in 2001, the sustainable growth rate, or SGR as we all know it by, a provision in the Balanced Budget Act of 1997, was in the process of being implemented, and under this payment formula, any yearly increase in per beneficiary spending that exceeded growth in GDP could result in a negative adjustment for physician payment in Medicare.

Dr. Price was really well aware of that. Clearly, this policy or the math didn't work, and for the next 15 years we had almost yearly struggles over what was aptly named the "doc fix." Seventeen of these doc fixes later takes us to last March when we came together in a bipartisan fashion with stakeholder input and CMS technical support to pass the Medicare Access and CHIP Reauthorization Act of 2015, or now commonly known as MACRA. With nearly 400 votes in the House, this legislation finally put an end to the sustainable growth rate so that doctors could focus on patient care and not worry about unpredictable payments.

We have called this hearing today to take our first look at the regulations released by CMS on April 27. We will look closely at how these regulations match up with congressional intent and what our Members and CMS are hearing from stakeholders as they digest 950 plus pages of regulations.

That is the scope of the hearing, to discuss the implementation of this truly historic legislative feat, and there is a lot in the proposed rule to discuss. So I know that on a bipartisan basis we are going to dive in, in a deep way.

Furthermore, I would like to take a moment to encourage Members of both sides of the aisle, as you hear from stakeholders and constituents regarding concerns or thoughts about the proposed rule, please bring them to the attention of the bipartisan Committee staff so that we can continue to do robust oversight and keep CMS up to date on the information as they formulate their final regulation.

The passage of MACRA last year confirmed our commitment on both sides of the aisle to keep Medicare strong for America's seniors. This is particularly important to me as well as many of you, especially after we just celebrated Mother's Day as both my parents, back in my district in Ohio, depend on this important Medicare program.

By replacing the way that physicians are paid and consolidating the separate quality measurement systems, we have taken a great step toward the ultimate goal of fully-integrated value-based care

through the incentivization of high-quality care. Now our role, as Congress, is to provide oversight, and in conjunction with CMS, to provide education on how this new law will work for the various types of clinicians and provider groups.

We need to answer how this rule will affect individual and small group providers versus larger groups. How will this rule affect specialty groups versus primary care physicians? How will the timing work for implementation under some potentially tight timelines? These are questions that I hope to get clarity on today in going forward through the implementation process.

As we move forward with implementation, I want to make sure that we, as Congress, recognize some very important facts regarding the law that we passed. The merit based incentive payment system, or MIPS is, and was, created as a budget neutral program. High-quality value-based care will take effort.

As I said before, such efforts must be recognized within the environmental and timing factors based in reality. And additionally, the thresholds for providers to qualify as advanced alternative payment models are high and are set in statute. Working on a bipartisan basis with stakeholders from every corner of our country in an open dialogue, with cooperation from CMS, will allow us to follow MACRA into the next generation of value-based health care.

Now we can go to work. With that, I would like to yield to the distinguished Ranking Member, Dr. McDermott, for the purposes of an opening statement.

Mr. MCDERMOTT. Thank you, Mr. Tiberi.

When Medicare was put in place some 50 years ago, a critical decision was made by the medical association in order to have them join in the effort, and they demanded that they be paid their usual and customary fees, and we, on this Committee, have been, since that time, trying to get back the keys to the Treasury. This is another effort here.

Now, the proposal by MACRA, or the MACRA rule from CMS is really as a result of our efforts, as Mr. Tiberi says, of 15 years of realizing what we put in place didn't work. It took us 15 years to figure out that we have to try to do something different.

Now, I hope this is the beginning of a constructive bipartisan conversation about how to advance our shared goal of controlling costs and improving the delivery of health care in the country. Passing MACRA was a tremendous bipartisan accomplishment in that it put an end to a cycle of dysfunction. We had the same thing happen every year. We are going to have a 20 percent cut in doctor's pay, so there would be a big rush around here and we would put a patch on it. And then we go on for another year, and next year it will be a 24 percent cut in doctors pay, and we put a patch on it. We did that again and again.

For years we lurched from crisis to crisis. And to avoid what were draconian cuts in the physician's payment, we ended up by spending more on those temporary delays than it would have cost to do away with the SGR in the beginning.

But last year, we put an end to this cycle once and for all by passing MACRA. I was trying to step forward, as MACRA is much more than just simple repeal of SGR. It is also the most significant payment reform the Medicare program has seen in years.

Thanks to MACRA, we have set Medicare on a more sustainable course that will allow us to pay for volume in health care—or excuse me, value in health care, rather than volume. The law modernizes and streamlines physician's payment. Instead of a patchwork of incentives and alternative payment models, it consolidates various programs into a single framework, it will allow flexibility for providers, it will allow them to practice medicine independently while still holding them accountable for providing high-value care.

These are complicated issues, and we are still in the early stages of digesting this proposed rule. It is big enough. It will take awhile. But what we have seen so far has been encouraging. The Administration has worked diligently to implement the law as intended through a process that is responsive to the needs of the public.

The proposed rule is consistent with the goals of MACRA. It provides flexibility to participate either in the merit-based incentive payment program, or alternative payment methods that reward high-value care. This will make sure providers do not end up in a one-size-fits-all approach that doesn't make sense to them or their patients. It is the product of an open and transparent process that began months ago through active outreach, consideration of extensive comments, and public workshops with stakeholders. The agency has heard from a range of viewpoints, and the proposal reflects careful consideration of that input.

I am confident the Administration will continue to be responsive to the needs of the public as it develops the final rule. This is an ongoing conversation. We still have much more to learn as we work toward our shared goal of making the implementation of this landmark law a success.

Getting the people covered by health care is one thing. Controlling the cost is another thing, and this is about controlling the cost, and I don't believe we have our arms around it yet, but we are in the process, and that is why we welcome you here, Mr. Slavitt, to make this presentation. Thank you.

Chairman TIBERI. Thank you, Dr. McDermott. Without objection, other Members' opening statements will be made part of the record.

Today's witness panel includes just one expert, and we are lucky to have him, Andy Slavitt, Acting Administrator at the Centers for Medicare & Medicaid Services, who, along with his colleagues, have the daunting task of implementing this very important law.

On a personal note, thank you for having me at your office yesterday. It was nice to get to know you and members of your team, and I look forward to continuing dialogue in the future.

With that, Mr. Slavitt, please proceed with your testimony, and we appreciate you being here today.

STATEMENT OF ANDREW SLAVITT, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES (WASHINGTON, D.C.)

Mr. SLAVITT. Thank you. Thank you, Chairman Tiberi, Ranking Member McDermott, Members of the Subcommittee, and thank you for the opportunity to discuss CMS' work to implement the Medicare Access and CHIP Reauthorization Act of 2015.

We greatly appreciate your leadership in passing this important law, which gives us the unique opportunity to move away from the annual uncertainty created by the sustainable growth rate to a new system that promotes quality, coordinated care for patients, and sets the Medicare program on a more sustainable path. Our number one priority is patient care. And thanks to Congress, MACRA streamlined the patchwork of programs that currently measure value and quality, into a single framework called the "Quality Payment Program" where every physician and clinician has the opportunity to be paid more for providing better care for their patients.

In recognition of the diversity of physician practices, Congress created two paths. The first allows physicians and other clinicians a new flexibility to participate in a single simplified program with lower reporting burden and new flexibility in delivering quality care.

The second path recognizes those physicians and clinicians who choose to take a further step toward care coordination by participating in more advanced models like medical homes. Our goal is to make both of these paths flexible, transparent, and simple so physicians can focus on patient care, not reporting or scorekeeping.

We have approached this implementation with the belief that physicians know best how to provide high-quality care to our beneficiaries, and we have taken an unprecedented effort to draft a proposal that is based directly on input from those on the frontline of care delivery. We have reached out and listened to over 6,000 stakeholders, including State medical societies, physician groups, and patient groups to understand how the changes we are proposing may positively impact care and how to avoid unintended consequences.

The feedback we received shaped our proposal in important ways, and the dialogue is continuing. Based on what we learned, our approach to implementation has been guided by three principles.

First, patients are and must remain the key focus. Financial incentives should work in the background to support physician and clinician efforts to provide the highest quality care and create incentives to more coordinated care.

Second, we are focused on adopting approaches that can be driven at the practice level, not one-size-fits-all from Washington. It will be important to allow physicians to define the measures of care most fitting with their patients.

Third, we must aim for simplicity in everything we do. Physician practices are already busy, and we are seeking every opportunity possible to minimize distractions from patient care by reducing, automating, and streamlining existing programs. Among the many places that we seek feedback during the comment period, this is among the most important as the burdens on small and rural practices, in particular, have increased over the last several years.

One of the important opportunities will be for physicians to define and propose new payment models so that we can create an array of customized approaches that reflects the diversity of care across the country, and particularly as it relates to the various specialties that provide care.

Congress had the foresight to create a formal voice for physicians through the Physician-Focused Payment Model Technical Advisory Committee. I had the opportunity to meet with them last week and can tell you that they are very eager to move forward with their important work, and we are eager to work with them.

With all the work that went into this proposal, it is critical that we receive direct feedback from physicians and other stakeholders and are undertaking significant outreach efforts. Our proposed rule is the first step in the process, and we look forward to receiving and reviewing comments to refine and improve our approach.

In the month of May alone, we have 35 scheduled events and listening sessions to hear from a wide range of stakeholders, and this outreach will remain an important part of our work. I personally have been meeting regularly with physician groups, including smaller and rural practices, and have spoken to thousands of physicians in different parts of the country about their work, the opportunities and challenges they face, and what this proposal means for them and their patients.

Throughout this, I have appreciated the open dialogue with this Subcommittee and the larger Committee, and it is clear to me that we share the goals of creating a more sustainable system with smarter spending that keeps people healthier.

We are striving to do just that in the implementation of MACRA, but it will take work and broad participation to get it right. I look forward to hearing your further thoughts on this implementation and to answering your questions. Thank you.

[The prepared statement of Mr. Slavitt follows:]

STATEMENT OF

ANDY SLAVITT

ACTING ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

IMPLEMENTATION OF MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

BEFORE THE

U.S. HOUSE COMMITTEE ON WAYS & MEANS

SUBCOMMITTEE ON HEALTH

MAY 11, 2016

U.S. House Committee on Ways & Means
Subcommittee on Health
"Implementation of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)"
May 11, 2016

Chairman Tiberi, Ranking Member McDermott, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss the Centers for Medicare & Medicaid Services' (CMS's) work to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We greatly appreciate your leadership in passing this important law, which provides a new opportunity for CMS to partner with physicians and clinicians to support quality improvement and develop new payment models to further our shared goals of a health care system that achieves better care, smarter spending, and healthier people and puts empowered and engaged consumers at the center of their care. As we take our initial steps to implement this important law, we have and will continue to work closely with you and listen to the physicians and clinicians providing care to Medicare beneficiaries, with the goal of creating a new payment program that is focused on the needs of patients and responsive to the day-to-day challenges and opportunities within physician practices. As we continue to transform the Medicare program, we are working to move beyond "one size fits all" measurements to an approach that offers multiple paths to value-driven care and recognizes and supports the diversity of medical practices that serve Medicare beneficiaries.

Today, over 55 million Americans are covered by Medicare[1] — and 10,000 become eligible for Medicare every day.[2] For most of the past fifty years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered. In the last few years, we have made tremendous progress to transform our nation's health care system into one that works better for everyone and rewards value over volume. Key to this effort is changing how we pay physicians and other clinicians, so they can focus on the quality of care they give, and not the quantity of services they order. Already, we estimate that 30 percent of

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-28.html
[2] http://www.medpac.gov/documents/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-(june-2015-report).pdf?sfvrsn=0

traditional Medicare payments are tied to alternative payment models (APMs). Generally speaking, an APM is a model that holds providers accountable for the quality and cost of the care they deliver to a population of patients by providing a financial incentive to coordinate care for their patients. This helps patients receive the appropriate care for their conditions and reduces avoidable hospitalizations, emergency department visits, adverse medication interactions, and other problems caused by inappropriate care or siloed care. This is a major milestone in the continued effort towards improving quality and care coordination. We expect this progress to continue, and we are on track to meet our goal of tying 50 percent of traditional Medicare payments to APMs by 2018 – especially in light of MACRA or the "Quality Payment Program."

The enactment of MACRA, which replaced the Sustainable Growth Rate (SGR) formula with a more sustainable way for paying physicians and other clinicians, provided new tools to modernize Medicare and opportunities to simplify quality programs and payments for these professionals. Currently, Medicare measures the value and quality of care provided by physicians and other clinicians through a patchwork of programs. Some clinicians are part of APMs such as the Accountable Care Organizations (ACOs), the Comprehensive Primary Care Initiative, and the Medicare Shared Savings Program—and most participate in programs such as the Physician Quality Reporting System, Physician Value-based Payment Modifier ("Value Modifier Program"), and the Medicare Electronic Health Record (EHR) Incentive Program. Thanks to Congress, MACRA streamlined these various programs into a single framework where clinicians have the opportunity to be paid more for providing better value and better care for their patients. CMS has proposed to implement these changes through the unified framework called the Quality Payment Program.

The Quality Payment Program gives physicians and clinicians the flexibility to participate in one of two paths. First, the Merit-based Incentive Payment System (MIPS) streamlines the three existing CMS programs into a single, simplified program with lower reporting burden and new flexibility in the way clinicians are measured on performance. MIPS allows Medicare clinicians to be paid for providing high value care through success in four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities, and Cost.

For physicians and clinicians who take a further step towards care transformation, the Quality Payment Program rewards physicians and clinicians through the second path, participation in Advanced APMs. Under Advanced APMs, physicians and clinicians accept more than a nominal amount of risk for providing coordinated, high-quality care for a set portion of their practice, such as Tracks 2 and 3 of the Medicare Shared Savings Program and the Next Generation ACO model.

Since the enactment of MACRA a little over a year ago, CMS has been developing our approach to implementation, and on April 27, 2016, CMS issued a Notice of Proposed Rule Making (NPRM).[3] CMS developed a proposal based on vital stakeholder feedback and input from the health care community. In our efforts to draft a proposal that would be simpler and meaningful for physicians and clinicians, we reached out and listened to over 6,000 stakeholders, including state medical societies, physician groups, consumer groups, and federal partners. We asked for comments[4] from the stakeholder community on key topics related to how to develop the measurements, scoring, and public reporting for the Quality Payment Program. We conducted multi-day workshops, and visited with physicians in their communities individually and in groups to understand how the changes we considered may positively impact care and how to avoid unintended consequences.

The input we have received from stakeholders has been invaluable and nearly universal: physicians and clinicians want support for a care system that improves coordination and reduces cost, but too many unaligned quality programs, measures, and technology requirements can hinder their best efforts to accomplish these goals. Based on what we learned, our approach to implementation has been guided by three principles. First, patients are, and must remain, the key focus. Financial incentives should work in the background to support physician and clinician efforts to provide high quality services, and the needs of the patient, not measurements, need to be the focus of our approach. Second, success will come from adopting approaches that are practice-driven. Quality measurement needs to accurately reflect the needs of a diverse range of patient populations and practice types and give physicians and clinicians the opportunity to select

[3] http://federalregister.gov/a/2016-10032
[4] http://federalregister.gov/a/2015-24906

elements of the program and measures that are right for their practice. Third, in everything we do, we must strive to make care delivery as simple as possible, with more support for collaboration and communication through delivery system reform. We know that physicians and clinicians strive to provide the best possible care for patients, and they deserve a program that encourages them to do so with flexible requirements that are as simple as possible while meeting standards of care that represent the highest quality of medicine and provide high value for the Medicare program. Among the many topics on which we seek feedback in the proposed rule during the comment period, this is among the most important, especially as we seek to create and enhance opportunities for small and rural practices while reducing administrative burden. .

We relied heavily on stakeholder input we received over the last year to inform our proposal of a scoring methodology for MIPS that aims to improve upon and streamline existing measures in the quality, cost, and advancing care information categories, which are based in part upon current CMS programs. In particular, we have been working side-by-side with the physician and consumer communities to address needs and concerns about the Medicare EHR Incentive Program, often known as Meaningful Use for physicians, as we transition it to the Advancing Care Information category in MIPS. The new approach heightens focus on the patient, increases flexibility, reduces burden, and concentrates on aspects of health information technology, such as health information exchange, that are critical for delivery system reform and improving patient outcomes. We also used this feedback when proposing the new clinical practice improvement activities category, which the statute created. When developing the proposed activities for this category, we listened closely to specialty societies and associations when creating options to allow clinicians to select activities that match their practices' goals.

While we expect that most clinicians will participate in MIPS for the first years of the Quality Payment Program, we will continuously search for opportunities to expand and refine our portfolio of payment models in order to maximize the number of physicians and clinicians who have the opportunity to participate in Advanced APMs. It is our intent to align the MIPS and the Advanced APM components of the Quality Payment Program, allowing maximum flexibility for clinicians to switch between MIPS and participation in Advanced APMs based on what works best for them and their patients.

The proposed rule is the latest step in our efforts to work in concert with stakeholders on the front-line of care delivery to draw upon their expertise and incorporate their input into the policies for the Quality Payment Program so that together, we can achieve the aim of the law. We eagerly anticipate comment on our proposal from all stakeholders and look forward to reviewing responses. Just as stakeholder input has been instrumental in the development of the proposed rule, the feedback we receive will be essential in our development of final regulations.

Notice of Proposed Rule Making (NPRM)

In our proposed rule, we provide details and descriptions of the proposed policies that will allow us to implement the important new provider payment provisions included in MACRA.

Merit-based Incentive Payment System (MIPS)

Currently, Medicare measures doctors and other clinicians on how they provide patient quality and reduce costs through a patchwork of programs, with clinicians reporting through some combination of the Physician Quality Reporting System, the Value Modifier Program, and the Medicare EHR Incentive Program. Through the law, Congress streamlined and improved these reporting programs into the Merit-based Incentive Payment System. Under MIPS, eligible physicians and clinicians will report their performance under four categories and will receive a payment adjustment based on their overall performance.

Consistent with the goals of the law, the proposed rule would improve the relevance of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. Under our proposed rule, performance measurement under the new program for physicians and other eligible clinicians would begin in 2017, with payments based on those measures beginning in 2019. MIPS allows Medicare clinicians to be paid for providing high quality, efficient care through success in four performance categories:

1. **Quality (50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program)**: Clinicians would choose to report six measures versus the nine measures currently

required under the Physician Quality Reporting System. This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.

2. **Advancing Care Information (25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as "Meaningful Use"):** Clinicians would choose to report customizable measures that reflect how they use EHR technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing Meaningful Use program, this category would not require all-or-nothing EHR measurement or quality reporting.
3. **Clinical Practice Improvement Activities (15 percent of total score in year 1):** Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in APMs and in Patient-Centered Medical Homes.
4. **Cost (10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use):** The score would be based on Medicare claims and require no reporting by physicians or other clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.

The law requires MIPS to be budget neutral. Therefore, physicians' and clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent; the positive adjustments will be scaled up or down to achieve budget neutrality. Also, in the first six years of the program, additional bonuses are provided for exceptional performance.

Advanced Alternative Payment Models (APMs)

For clinicians who take a further step towards care transformation, the law creates another path. Physicians and clinicians who participate to a sufficient extent in Advanced Alternative Payment Models would qualify for incentive payments. Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a physician or clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Under the law, Advanced APMs are those in which clinicians accept risk and reward for providing coordinated, high-quality, and efficient care. As proposed, Advanced APMs must generally:

1. **Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures. We propose that the amount of risk must meet the following standards:
    - Total risk (maximum amount of losses possible under the Advanced APM) must be at least 4 percent of the APM spending target.
    - Marginal risk (the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM is responsible; i.e., sharing rate) must be at least 30 percent.
    - Minimum loss rate (the amount by which spending can exceed the APM benchmark (or bundle target price) before the Advanced APM has responsibility for losses) must be no greater than 4 percent.
2. **Base payments on quality measures comparable to those used in the MIPS quality performance category.** To meet this statutory requirement, we propose that an Advanced APM must base payment on quality measures that are evidence-based, reliable, and valid. In addition, at least one such measure must be an outcome measure if

an outcome measure appropriate to the Advanced APM is available on the MIPS measure list.

3. **Require participants to use certified EHR technology.** To meet this requirement, we propose that an Advanced APM must require that at least 50 percent of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. This requirement increases to 75 percent in the second performance year.

In addition, under the statute, medical home models that have been expanded under the Innovation Center authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While medical home models have not yet been expanded, the proposed rule lays out criteria for medical home models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

The rule proposes a definition of medical home models, which focus on primary care and accountability for empaneled patients across the continuum of care. Because medical homes tend to have less experience with financial risk than larger organizations and limited capability to sustain substantial losses, we propose unique Advanced APM financial risk standards, consistent with the statute, to accommodate medical homes that are part of organizations with 50 or fewer clinicians.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule as Advanced APMs. These include:

- Comprehensive ESRD Care (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program – Track 2
- Medicare Shared Savings Program – Track 3
- Next Generation ACO Model
- Oncology Care Model – Two-sided risk (available in 2018)

Under the proposed rule, CMS would update this list annually to add new payment models that qualify. CMS will continue to modify models in coming years to help them qualify as Advanced

APMs. In addition, starting in performance year 2019, clinicians could qualify for incentive payments based in part on participation in Advanced APMs developed by non-Medicare payers, such as private insurers, Medicare Advantage plans, or state Medicaid programs.

We recognize the substantial time and money commitments in which APM participants invest in order to become successful participants. Under the proposed rule, physicians and clinicians who participate in Advanced APMs but do not meet the law's criteria for sufficient participation in Advanced APMs, and those who participate in certain non-Advanced APMs, would be exempt from the cost category in MIPS, would be able to use their APM quality reporting for the MIPS quality category, and would receive credit toward their score in the Clinical Practice Improvement Activities category. We want to make sure that in addition to encouraging physicians and clinicians to improve quality of care by participating in APMs that best fit their practice and patient needs, physicians and clinicians are not subject to duplicate, overly burdensome reporting requirements.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

To help spur innovation for models that meet the needs of the physician community, MACRA established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will meet at least a quarterly to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The eleven members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The PTAC has met twice and presentations from the meeting are available online.[5] I personally attended the second meeting on May 4, 2016. CMS looks forward to receiving these critical recommendations for new physician-focused payment models. We encourage physician specialists and other stakeholders to engage with the PTAC to suggest well designed, robust models. We are committed to working closely with the PTAC and are looking forward to reviewing their recommendations.

[5] https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee

Technical Assistance

We know that physicians and other clinicians may need assistance in transitioning to the MIPS and we want to make sure that they have the tools they need to succeed in a redesigned system. Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as Quality Improvement Organizations, regional extension centers, and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to prepare for and set up support for physicians and clinicians to be successful under MIPS criteria, making it as seamless as possible for these clinicians and practices to comply with MIPS requirements while helping interested practices transition to implementation of and participation in an APM. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance, and details regarding the technical assistance program will be addressed in future guidance.

In addition to MACRA implementation efforts, in September 2015, CMS awarded $685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks.

Conclusion

MACRA will help move Medicare towards more fully rewarding the value and quality of services provided by physicians and other clinicians, not just the quantity of such services. For it to be successful - in other words, for MACRA to improve care delivery and lower health care costs – we must first demonstrate to clinicians and patients both the value of these new payment programs established by MACRA and the opportunity for them to shape the health care system of the future. The program must be flexible, practice-driven, and patient-centered. It must

contain achievable measures; it must support the continued development of health IT infrastructure through interoperability; it must engage and educate physicians and others clinicians; and it must promote and reward improvement over time.

Our proposed rule incorporates input received to date, but it is only a first step in an iterative process for implementing the new law. Moving forward, we will continue to gather feedback to inform an implementation approach that leads to better care, smarter spending, and improved patient outcomes. We will continue partnering with Congress, physicians and other providers, consumers, and other stakeholders across the nation to make a transformed and improved health system a reality for all Americans. We look forward to working with you as we continue to implement this seminal law.

Chairman TIBERI. Thank you, Mr. Slavitt. As you know, in my district, I represent urban, suburban, rural, and most of the concerns I have heard with respect to MACRA and the future implementation of MACRA is from small and rural providers' practices.

So the proposed regulation assigns three levels of risk required for entities participating in the APMs, the alternative payment models. And what I have not seen are any tiers or variabilities in the amount of risk for participation between an individual and small group clinician and large group clinicians.

Have you heard concern from providers about this?

Mr. SLAVITT. Thank you for the question. I think the topic of particularly small practices and making sure that they can succeed is of utmost importance, and our data shows that physicians that are in small and solo practices, so long as they report, can do just as well as physicians in larger size practices.

So we know, however, that there is a burden on us to make the reporting as easy as possible. We also know there are a number of other steps that we need to be looking for, and looking out for, to make sure we make things as easy as possible and accommodate smaller practices.

So importantly, we are looking for additional steps and ideas as people review the rule, but I will say that we are focusing on technical assistance, providing access through medical home models, opportunities to report in groups, and using a reporting process that automatically feeds data, reduces the number of measures, and overall lowers the burden for small practices.

Chairman TIBERI. So in a followup to that, in reading through the regulation, there are several areas that seem to allow a little more flexibility for individual and small group practices. Can you outline some of the major differences in reporting for individual and small group practices versus the larger groups that could maybe ease the burden or send the message to the smaller groups that there is sensitivity there?

Mr. SLAVITT. Sure. Absolutely. First of all, at the request of the physician—we met with a lot of physicians and physician groups and small practices in this process. One of their key requests was that if they are already participating in something like a clinical registry or some other way of getting data across that may be an accountable care organization or clinical registry, that we use that information rather than requiring them to send it again, and our proposal does indeed allow multiple ways for us to get information.

Second, we are required to measure the cost of care, and we are going to be able to do that automatically by getting a claims fee, so it is going to require physicians to send us no information whatsoever. And then there are a number of areas where they will simply need to attest to whether they are doing a certain activity, which we think will reduce the burden, and we are looking more broadly at the overall experience for physicians. Small physicians can report in groups in many categories where they hadn't been able to before, and then finally, I would say, there are a large number of physicians who won't have to report at all because they will be underneath their minimum threshold. Congress put forward that if physicians don't see enough Medicare patients or meet the

minimum threshold through Medicare, they don't have to report at all.

So all of those things, I think, are there. And again, we also look for additional steps, if there are some, that we can take.

Chairman TIBERI. Just a final thought, and I don't mean to put you on the spot on this, but do you think there is any more that we can do, those of us on this side of the dais, and you and your team at CMS, to ensure that, as we lay the foundation for MACRA going forward and there is buy-in, complete buy-in from the physician community, that the system is not built with an inherent fairness or fairness issues—again, going back to the rural provider or the two-person provider group that has a bunch of angst right now——

Mr. SLAVITT. Right.

Chairman TIBERI [continuing]. As this has begun to unfold. Is there anymore that we can do, or you can do, or we can work together on?

Mr. SLAVITT. Yeah. I think it has to be a vital continuous effort. Last week I met with small physician practices from southern Arkansas, southern Oregon, and New Jersey. We had a meeting on Friday with Rural Health Association at their annual meeting. We went out to Kansas City last week to meet with the Family Practice Association, and we do hear a lot from small physicians who are concerned, and I think they are particularly concerned if people in Washington are making centralized decisions that are going to impact their quality of care.

And what they tell us over and over again, and we need to keep talking to them and getting more feedback, is give us the freedom to take care of these patients. We know how to do it, let us define quality, let us select the measures that are right for our practice, give us more flexibility, and don't make us focus on reporting. Let us focus on patient care. And it is really critical, I think, as we work together and as you hear input, that you get this to us and that we hold ourselves very much to that standard that physicians across the country are holding us to.

Chairman TIBERI. Thank you, sir. With that, I recognize Dr. McDermott for 5 minutes.

Mr. MCDERMOTT. Thank you. One of the issues that the questions Mr. Tiberi is raising about small practices sort of leads me to the question of consolidation and driving doctors together in larger and larger groups. The question then comes to my mind—I practiced both as an individual, and in the military, and in a group practice, so I have been in all sorts of forums. One of the things that strikes me that is going to be difficult to deal with here is the whole question of what is the best care.

If you have a large organization and they have an MRI and they don't want to use it, or they want to use it, they can crank a lot of people through an MRI for everything, or they can say don't use an MRI, and there will be patients out there who do not benefit from what they could find. I can give you an example of a young woman, 34 years old who had pain in her back, and was told there was—you know, you are riding a bicycle, and there is a lot of reasons why, you know, you are young, and blah, blah, blah.

At 35, they did an MRI and found a tumor in her spine. Now, if they had done that, they would have found it 5 years earlier, but the organization was encouraging people not to use. So how are we going to make our judgment about whether we have quality of care, if the major factor is going to be money? I mean, what is built into this to actually look at the quality of care?

Mr. SLAVITT. Yeah. So I think at the heart of the question, the most important thing above all else is making sure patients get high-quality care, and we do believe that if patients are getting high-quality care, that is going to lead to better cost control because if someone gets the right surgery, they won't need to have a second surgery.

Likewise, quality is also defined as making sure the care is coordinated, so if somebody needs to have a followup visit or has a prescription or something with an instruction, that they understand what that is, it is explained to them and that the system works and supports them. So our job here is to enforce that, number one.

Number two, I think our job isn't to define quality here ourselves as much as it is to take the best standards of care that the specialists and the physicians around the country have defined as quality and make sure that we keep up with that and that we keep those measures as the things that physicians decide, as a group, that they should be measured on, and those are the things—and then third, as I said earlier, that at the practice—things actually differ at the practice level.

And we believe the practice is, by and large, are the people that know best for what is right with their patients, and that the dialogue between the patient and the physician—so nothing we are doing should be seen to be interfering with that in any way. And in fact, we ought to be reinforcing those things, and I think MACRA gives us the opportunity to say if you are delivering a better quality of care outcome for your patient, you ought to be rewarded for that.

Mr. MCDERMOTT. You are suggesting the whole question of evidence-based medicine, that is, I mean, I have been to the doctor recently, and they send out, from the University of Washington, a sheet to me, and it says did you have good care. Well, was he polite, was he nicely dressed, and blah, blah, blah, down at the bottom, were you satisfied with your care?

Now, for some people, if they don't get a prescription or they don't get an X-ray or they don't get a blood test or they don't get something, they haven't had—the doctor hasn't done anything.

Mr. SLAVITT. Right.

Mr. MCDERMOTT. So how do you measure then the patient who says, well, I wasn't satisfied because I went away and I still ain't got—my sinuses are a mess and he didn't give me antibiotics. How do you deal with that issue in the quality of care?

Mr. SLAVITT. Sure. I think one of the nicest things is—I will give you an example. I was sitting down with some physicians that are practicing medicine in southern rural Arkansas, I referred to them recently. They are in one of these models, a medical home model, where they have a per member, per month payment they get in order to coordinate the care, and they have hired care coordi-

nators, and what they told me was, the physician I was talking to told me, he said, now I actually can get paid to practice medicine the way that I am supposed to practice medicine instead of practicing medicine the right way and getting paid on something completely different.

So I think the more we evolve our healthcare system to a way that reinforces what physicians know are the right things to do in delivering quality of care to patients, the better off we are going to be, as opposed to a system where if you don't make a cut in someone's skin or give them a prescription or something that they leave the office with, that is not success.

Mr. MCDERMOTT. I have a medical home at the University of Washington. Thank you.

Chairman TIBERI. Thank you, Dr. McDermott. That was really good. We agree on something.

Mr. Slavitt, thank you so much. You know, I have 12 different questions I could ask you on 12 different topics, and my mom has one that she shared with me last night she wanted me to ask you. But it doesn't have to do with MACRA, so that is for another day, and I would like to remind all Members to try to keep the topic to this important law that we passed.

With that, Mr. Johnson is recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Slavitt, welcome. You have said that CMS is working to regain the hearts and minds of physicians through implementation of MACRA, and that is great because many physicians in solo and small practices have really struggled to stay afloat in recent years.

And while there are a lot of good things in the proposed rule, I have one issue I would like to raise with you. I am concerned by the estimates in table 64 where CMS projects the greatest negative impact on payments to practices with 9 or fewer doctors and the least harm to large systems with 100 or more docs. If CMS is trying to win back the hearts and minds of physicians, this proposal falls short since it will continue to push physicians out of their solo or small practices.

Can you tell me specifically what CMS is doing to ensure that solo practitioners and small groups can succeed under the MIPS and participate in alternative payment models by 2019?

Mr. SLAVITT. Thank you. Thank you, Congressman Johnson, for the question, and I really would actually welcome the opportunity to address this table, and for anyone who hasn't seen the table, the table is designed to estimate what the impact of these regulations could be on practices of various sizes.

And the first thing I want to make very clear is that the question of making sure that small groups and solo practitioners can be successful is of utmost importance, and I would also indicate that despite what that table shows, our data shows that physicians who are in small and solo practices can do just as well and actually do just as well as physicians that are in practices that are larger than that.

Now, the reason that table looks the way it does is for one very simple and important reason. It accounts for the fact that in 2014, when the table the data uses, most physicians in small and solo

practices did not even report on their quality, and this is important for a couple of reasons.

First of all, I should say that in 2015 and subsequent years, the reporting went up, so at best, this table would be very, very conservative, and of course, as I explained to Chairman Tiberi, reporting is going to get far easier going forward.

But it does point to a couple of things that I think we would be wise to pay attention to. One, making sure that it is as easy as possible for physicians to report. One of the reasons why we don't have the hearts and minds of physicians is because there is just too much paperwork in health care.

Mr. JOHNSON. I would agree.

Mr. SLAVITT. They need to be practicing medicine, not doing paperwork. So there has been a tremendous amount of effort so far, and this is just a proposal. So this next period of time for comments is a time when we are hoping people can give us even further ideas and further ways that we can reduce the administrative and reporting burden. But to be very clear, there is absolutely every opportunity, and in fact, an equal opportunity for small and solo practices to be successful.

Mr. JOHNSON. Well, thank you. Maybe we better indoctrinate the nurses, too. Don't they do most of that?

I thank you, Mr. Chairman. I yield back my time.

Chairman TIBERI. Thank you, Mr. Johnson.

Mr. Kind is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman. Thank you, Mr. Slavitt, for your testimony here today. Needless to say, I think Congress, in passing MACRA, gave you a huge undertaking, and now with a 900-page rule, I think it is pretty obvious that we are going to need to keep the lines of communication open, and hopefully your outreach with the stakeholder groups will continue as it has been, with not just physician but patient feedback as well.

I know many Members of this Committee, myself included, have been pushing hard to move to a more integrated coordinated healthcare delivery system. I come from a region of the country in Wisconsin that established models of care, and has been pushing aggressively in this direction for quite some time. And then ultimately, you know, alternative payment methods so we get the quality, value-based, outcome-based reimbursements. And again, that is kind of the directive that MACRA gave you.

But also a lot of my providers were early stage first generation ACO models. My question is, what more can be done in order to provide an on-ramp for advanced APM payments to those early stage ACOs, or are they going to have to just leapfrog and go on to Gen 2, Gen 3, Gen 4?

Mr. SLAVITT. So you are raising a very important question, which is where physicians have an opportunity—as we mentioned, all physicians in every program will have the opportunity to get rewarded for quality care, but where physicians have an opportunity to and have had the opportunity over the last several years, to join with other physicians in these more coordinated care models, the medical home would be one example, we think those are a good idea. We think they are a good idea if they are right for the physician, if the physician thinks they make sense for their patients,

and of course, it creates an opportunity in its own right to earn more.

What MACRA does is it gives physicians an even additional opportunity, an opportunity to earn 5 percent additional bonus on top of what they may already be earning in these advanced models. So the question is: What is the requirement to get access to that 5 percent bonus? And the legislation puts forward a number of requirements, and the requirement really, in a nutshell, if I were going to simplify it, is that there has to be a higher degree of shared accountability from the physician, and that shared accountability is shared accountability for the outcome to the patient and a minimal sharing of the costs with the Medicare program itself.

So in other words, in order to qualify for this 5 percent bonus, I think the words that are in the legislation are there has to be a more than nominal risk.

So our job in putting this regulation together is to put the definition around what is that nominal risk. We have tried to do that in as consistent a way as possible and as simple a way as possible, but really it is one of the areas where we really are inviting feedback. And then all of our models, whatever model we are in, will have to qualify based upon that definition.

And so even if a physician is in a model that doesn't qualify because there is not as much nominal risk, there is still great opportunities, and there is still opportunities for them to grow into other models.

Mr. KIND. Well, finally, you know, the great cost driver in our society, and it is true at the Federal level at the budget, at State and local, for families and businesses alike, is rising healthcare costs. So with the direction this rule is taking, can we sit here with reasonable confidence that this may ultimately lead to some cost savings but without jeopardizing the outcome or quality of care that our patients are receiving? Or is this going to turn into a Lake Wobegon type of situation where everyone is above average, everyone is qualifying for bonus payments, and there is no real cost savings at the end of the day?

Mr. SLAVITT. Right. Well, I think, first of all, we all are striving for a higher quality healthcare system. We all want our money spent more wisely, and we don't want to do it in a way that people feel like they are getting—skimping on their care. We have 10,000 new seniors every day in America, and our jobs are to be able to figure out how to take care of them better for less money. And that means being able to take care of them in lower cost settings, more comfortable settings like their homes rather than in institutions like hospitals, and so those types of incentives are vital to this program.

Within the regulation, there are—the pool balances out, and so we are going to have to allocate money and have upward and downward adjustments as part of this program in order to be able to meet the sustainability test you talked about. That is nothing new. There are upward and downward adjustments in programs today. What is new is that this will be a simpler more aligned program that is easier to measure and keep track of.

Mr. KIND. Great. Thank you. Thank you, Mr. Chairman.

Chairman TIBERI. Mr. Roskam is recognized for 5 minutes.

Mr. ROSKAM. Thank you, Mr. Chairman. Mr. Chairman, I have an observation, a point, and a nudge.

My observation is this: There is a level of anxiety that is out there in our public life today because people look at Congress and they say nothing is happening. And yet here we have this issue where both sides of the aisle, the White House, everybody came together, wrestled a very complicated issue to the ground, came up with a solution, and it doesn't involve snarling at one another on television, it doesn't involve, you know, a hyperbole and so forth, but there was this very serious effort, and we are on the verge of, I think, some good things.

So just a little shout out, and that is, three cheers for something getting done, and I think there is an encouraging element to that.

My point is that debate matters. I would argue that one of the reasons that we were able to have that discussion, when Speaker Boehner and leader Pelosi were able to come together, and the two of them really drove the discussion, it was because it had been well wrestled through in the United States over the past several years that we need to do something on Medicare. And both sides have different views of the world and so forth, but it had become normalized in that sense that these things had to change.

So debate does matter, and I think we are better off if our debate doesn't involve snarling at one another, and it is two various points, but debate matters because debate is a prelude to action. Margaret Thatcher said: First you win the debate, then you win the vote.

Okay. Now here is the nudge, and this is the nudge for you, Mr. Slavitt. One of the things that I think you and I have talked about offline, and you have alluded to some of this, too, a minute ago, there is this tension that is out there, and there is a tension that manifests—and let me just tell you a quick story.

I served in the State legislature, and we had some education testing issues that came before us, and you know how this works. There is always a new test, there is always a new standard, so I called a friend of mine, who is an old friend from high school, who is a high school administrator, and I said: Give me the straight scoop on these tests.

And he said: Peter, look, will you just pick a test and stick with it and not change it every 4 years? He goes: We are happy to be accountable, but stick with the test, stick with the program. And that deeply resonated with me.

So the tension is that I think healthcare providers want a standard, they want something that is predictable, but now, also, the tension is they don't want something that is declarative and dispositive and can never be revisited because that is big and that is overwhelming and that is what SGR had—that is what we had to do for, you know, the doc fix for all those years. That was declarative. It was an overcharacterization, and it failed. And the proof that it failed was you had to kick—we all had to kick the can down the road.

So my nudge is this: As you are going through and you are figuring this out—and I really appreciate the disposition and the attitude and the open rule time that you have now and the comments that you are taking in, if you could really be mindful of those

smaller practices that Mr. Johnson mentioned, the point that Mr. McDermott made, and that is, how is it that a physician that is stewarding antibiotics correctly or not giving in to patient pressure for a prescription, how is that physician protected? Also, I hadn't thought about it until Mr. Kind mentioned it, are the bonus payments a new floor, and does the average become the expectation?

So, I am here, and I think that the Chairman has set the great tone here, and that is for us to listen and to learn, but as you are navigating through those natural tensions of having something that can be predictable but also maintaining that level of flexibility where it can be revisited and changed, I think is the best of both worlds.

And with that, you don't need to respond. I'll yield back. Thank you.

Chairman TIBERI. If you would like to respond, you may. It is up to you.

Mr. SLAVITT. We had this conversation, including a little bit, yesterday. I think this idea of making sure that people don't feel like the game is changing on them, made porous, is critical. So there is enough in this legislation that allows us to tell folks going in, hey, here is how it works, in advance. I think there is nothing more frustrating than being told after you took the test how it is being graded.

And then I think you make an important point as well, which is how do you trade off making sure you are predictable, with staying current with the state of the art of the state of medicine, and what physicians are saying that they want, and I think we have a process for that, we take comment on that process, we think it is an effective process, but it is also important that physicians have the flexibility to navigate the process, particularly at different times in their practice.

Chairman TIBERI. Thank you. Mr. Thompson is recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman, for having the hearing today. Thank you, sir, for being here. I am sorry I had to step out, so I hope I am not going to be repetitive here.

But we are all very, very interested, I think you can tell by the tone of all the questions, that this law works. We have a very vested interest in that, not only as a Committee of jurisdiction, but also these are the people, providers, and patients that we represent at home, and we want to make sure that it works.

And so to that end, I would like to hear what the Administration is doing to help providers get ready ahead of the 2017 start date, and what would you recommend providers be doing to get ready, and is there anything that we, as Members of Congress, should be doing to help facilitate this transition?

Mr. SLAVITT. Yeah. Thank you. So I guess maybe I will start to direct that question as if what I would say to a physician who was wondering what does this all mean, and it is a conversation that I get to have frequently because I have been having a lot of conversations with physicians, and I think there are probably 5 things I would say that I would keep in mind as a physician or from, I think, our perspective.

Number one and most importantly, keep focusing on your patients and on patient care. Don't worry about the scorekeeping. It will be our job to put this forward in a way where it becomes easier, and indeed, it will be easier and more streamlined than the processes that people have to go through today, so that is the good news, and that is the first thing.

The second thing is, we have to continue to talk to people and educate people as there are opportunities. As the Chairman's question implied earlier, because physicians will have the opportunity to decide which measures and which ways the measuring quality they want to be measured on, at some point they will be able to think about what those things are and they will be able to put those in motion, and that is really one of the important early things.

I think if there are opportunities to participate in these more advanced models, these care coordination models like medical homes, they should obviously consider those because there are some extra rewards for that, but it won't be until the spring of 2018 that physicians would first need to report on MACRA. And so it is important that they not get too concerned about that.

And then the final thing I would say, and I think what we are trying to encourage for everybody, is to provide us feedback. During this comment period, we really want physicians to be able to review this. We are setting up a number of sessions. I talked to 3,000 physicians yesterday on a call. We do twice a week webinars to get your questions answered and then ask you to give us feedback on how you think this is going to affect your practice.

Mr. THOMPSON. And as far as us being able to do anything to help facilitate the transition, any comments for the Committee?

Mr. SLAVITT. I think the more listening sessions and open forums that there can be with physicians, and giving physicians an opportunity not just to hear what is in the rule but to tell us how it is going to impact them—I spoke with one of the Members of the Subcommittee who asked me to participate in one of those sessions with people in his district. I think we have a lot of the staff at CMS that are available to do phone calls and other things to reach out directly, so let us know what you are hearing from your constituents, and our job is to be responsive.

Mr. THOMPSON. And so in my particular case, would you rather do a phone call to the Napa Valley or would you rather come out and do it in person? I yield back.

Chairman TIBERI. Maybe a future Subcommittee hearing.

Dr. Price is recognized for 5 minutes.

Mr. PRICE. Thank you, Mr. Chairman, and thank you, Mr. Slavitt, for joining us today. I think, as has been said, I think we are moving in a better direction, but we still have a long way to go, and if we are going to make it so that physicians can once again be able to care for patients without an inordinate amount of influence or burden from outside, we have to continue to work through this, and I appreciate your willingness to do so.

I have a couple of specific areas, and then I want to tick through.

One is you have the moving from meaningful use to ACI, whatever we want to call it, we have the 365-day rule. In the past, it has always been a 90-day rule, which means that the practice has

to demonstrate that they comply for a 90-day continuous period within a 365-day period.

It only makes sense, nobody is perfect every day, and if they are going to get dinged because they are not able to comply 1 day or 2 days or 3 days, then we have simply got to move to a 90-day, and I hope that you are able to work in that direction.

Mr. SLAVITT. So it is one of the key areas we are inviting comment right now during the comment period.

Mr. PRICE. Good. So I invite comment as well from folks from whom I have heard.

Mr. SLAVITT. Okay.

Mr. PRICE. On the alternative payment models. You have a lot of folks out there, a lot of docs, guys, and gals who have already modified what they are doing. The bundled payment, BPCI programs, the future CJR program, and yet it appears that those programs, that CMS has pushed on docs, and encouraged docs, and incentivized docs, don't even qualify for APMs. That doesn't make any sense at all.

So I hope you are looking at just grandfathering those or moving them in or allowing them to qualify as APMs.

Mr. SLAVITT. So Congressman, one of the things that I think we have to do now that the law is being implemented is to go back and look at all of our models and see where we can make changes to them so that the participants in them can qualify. And I know that Dr. Conway is very much directing the team to look for ways to do that where possible. They have to meet—there are certain requirements that have to be met.

An example would be what percentage of the patients I am seeing are part of this bundled payment, and so that is because that is in the statute and the law, we have to look at how we can modify these programs or work with you on what our flexibility is to be able to——

Mr. PRICE. I agree. If you expand the ability for them to use their entire practice instead of just Medicare, that oftentimes gets them to that point.

Mr. SLAVITT. Right.

Mr. PRICE. So I would urge you to look at that.

Mr. SLAVITT. Okay.

Mr. PRICE. Docs are really frustrated with things for which they are being held accountable that they have no control over. One of them is on the meaningful use, ACI issue, this data blocking that is occurring by the vendors. Docs don't have any control over what the vendors do at all, so how we can have a system that actually punishes docs or potentially punishes docs because of what somebody else does that they don't have any control over, again, that doesn't make any sense at all, and they are pulling their hair out trying to comply with this, so if you can look at that, that would be appreciated as well.

Mr. SLAVITT. Will do.

Mr. PRICE. I want to touch on the nominal risk that you talked about. The nominal risk, as I understand it, is a minimum of 4 percent of total spending to be qualified under an APM.

Mr. SLAVITT. That is correct.

Mr. PRICE. And as you know, the physicians control, I don't know, pick your number, 14, 15, 16 percent of total spending. So 4 percent of total spending is really a 25, 30 percent hit for the docs. So how can we have a system that punishes the people that are—where the rubber hits the road, trying to care for these patients, and again for which they have little control over? Shouldn't that be 4 percent of the physician total reimbursement?

Mr. SLAVITT. One of the areas where we are looking for feedback in the comment period is both what is nominal risk quantitatively? We have chosen a number that was consistent across the MIPS program, but that is just in the proposal.

Mr. PRICE. Doesn't that presume that the physician controls every dollar of spending?

Mr. SLAVITT. And that is the second area where we seek feedback, which is, under what universe total cost of care, which of course the benefit of a total cost of care is a primary care physician has the opportunity to get rewarded for being able to keep the patient out of the hospital when they don't belong there and so forth. Of course, as you point out, it is an area where we are looking for feedback and very much hearing that perspective.

Mr. PRICE. A lot of those things are out of their control.

Mr. SLAVITT. Sure.

Mr. PRICE. We would like to believe that they control them, but in an ideal world, that might be nice, but a lot of those things are out of their control.

I have a few seconds left, and I just want to point out, once again, the table that you identified, table 64, which by your own data, stipulates that 87 percent of solo practitioners are going to see a negative adjustment. This is your own data. Granted, it is 2 years old, but it is going to be 2-year-old data that is going to reward them in 2019 based upon what happens in 2017, so I would urge you to relook at how you are adjusting that, and in realtime, providing an update.

Mr. SLAVITT. Right. Right. And we are going to look in the final rule at having the most updated and most accurate information in that table. Again, while that table would not be good news for reality, I don't believe it is reality, however I will say that the silver lining is I think drawing attention to the impact of this regulation on small and solo practices is a good thing, and so I think it is where we need to have dialogue, and so despite the fact that I don't think that table represents the reality, I do think that the reality of how difficult it is to practice medicine in a small or solo practice is very real, and so we are looking for ways to make sure we make it better.

Mr. PRICE. Great. Thank you very much. Thank you, Mr. Chairman.

Chairman TIBERI. Thank you. I think you might be sensing a theme up here.

Mr. Blumenauer, you are recognized for 5 minutes.

Mr. BLUMENAUER. Thank you, Mr. Chairman. I appreciate the opportunity to have the conversation today. Mr. Administrator, I appreciate the approach that you folks have taken to help us turn the corner.

I personally have found the charade we went through for some 17 years kind of embarrassing, dancing away from an event we know nobody had any expectation should happen. We were dealing with a budget fiction.

I think the agreement that was struck is reasonable. There is still much value to be squeezed out of the system, but I appreciate the fact and some of the references from my friend, Dr. Price.

We have people who are in the middle of practice patterns, limitations on data, and just a whole host of other changes taking place, and I appreciate the commitment to do so in a thoughtful and deliberate fashion.

You have also heard another theme emerge that people are keenly interested in making sure that we make this transition to rewarding value over volume, and that we have had problems in the past with some things, theoretically. I mean, I have strongly supported Medicare Advantage, but at the same time, parts of the Affordable Care Act to try to coax more value out of it because, theoretically, it should enable us to deliver care more efficiently, and we continue to have a pretty significant premium.

The compromise that was struck, and one that I thought was healthy, was to provide bonuses based on performance and try to deal with some of the areas where there is some decidedly, I don't know if one wants to call them outliers, but there are some real performance problems being overcompensated, coming from one of those regions that we like to think that if everybody practiced medicine like they do in my congressional district, we wouldn't have the funding problems that we have.

You know, I am looking at charts like this that kind of display how it is supposed to work over time. I wonder if you can just give us a sense of where you think the pinch points are, where will some of the things that we need to be prepared to be able to work with you be, if there are further adjustments legislatively, if there are things that we need to do a better job of just being able to understand ourselves, to explain to our community at home, where are the pinch points you think we need to zero in on?

Mr. SLAVITT. Thank you, Congressman Blumenauer. I think I point to a couple of areas that I think are really critical focus areas for us. One is the education and communication process, particularly with smaller practices and individual solo physicians. It is vital that we hear their feedback and understand what the impact of the decisions that we are making here today will be on their practices several years from now. So that education process, I think, means a couple of things.

One is that we talk in plain English instead of acronyms, which we are quite guilty of here, I know, but we are trying very hard to do a better job with that. We have created simple fact sheets, and training sessions, and PowerPoints, and as many options as possible to do that, and to the extent that you can help us do that and tell us what you are hearing, that is going to be critical.

The second thing that I think we will need to continue to hear from you all on, and I think the conversation with Congressman Price is apropos to this, is where there are places where you think there should be flexibility and how we should be exercising flexibility, whether it is with smaller practices or whether it is in how

we define the models that qualify for the 5 percent bonus, and in all of those areas, your feedback on our interpretations is critical because we really do want to get to the best answer.

And I will tell you that we don't have a monopoly on that. We want to do that through the dialogue and the debate that Congressman Roskam referred to, and we also are going to have to make this an ongoing commitment because we will have to look at this program at the end of its first year and understand what worked well and what didn't and what can work better, and we can't be afraid to call out the things that didn't work as well and sit down together and try to figure out how to make those things better, whether it is with technical improvements or whether it is simply in how we are implementing things.

Mr. BLUMENAUER. Mr. Chairman, I do appreciate the opportunity to get into something, which I hope we are able to periodically review and update. I appreciate that part of this is process and part of it is performance, and being able to strike that balance in a way that is protective of the people who depend on this service but also of the taxpayer, I think, is going to be a challenge for our friends at CMS and for the Committee, and I hope we can continue sort of zeroing in in that fashion. Thank you.

Chairman TIBERI. Thank you. Well said. Mr. Smith of Nebraska is recognized for 5 minutes.

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman. Thank you, Administrator Slavitt, for being here today. I represent a very rural district, and some parts more rural than others, in fact. With 75 counties touching six States, obviously, we are very spread out. We are the number one agricultural district in the Nation, very productive. Of the nearly 60 hospitals in my district, about 54 are designated as critical access, and that might be a single designation, but that is about 54 different types of expertise and providers, and I am actually inspired by the work that they do serving communities from smaller than 1,000 up to about 12,000 plus. Nonetheless, they have a very large task, and I guess so do you.

Can you discuss the feedback you received from rural providers in response to the initial RFI and how you addressed that in producing the rule and then what rural providers and critical access hospitals can expect from this rule?

Mr. SLAVITT. Yeah. Thank you, Congressman. And in your district, and I think throughout the country, you know, we face the challenge of not having enough physicians, in many cases enough specialties, and there are many districts around the country where there are, you know, only one or two providers in certain specialties. So we cannot allow the sideshow that goes along with the practice of medicine to make the practice of medicine less fulfilling and less rewarding.

So as it relates to the small physician practices, the medical home models that many of them are participating in, we have had really terrific feedback from, and I think what I hear from small physicians is: give us the opportunity, find ways for us to have the opportunity to participate in some of these same opportunities, the models that people do in urban settings and make them work for us. So can you make changes to them that can work for us? That is, I think, one of the things we——

And then on critical access hospitals. Obviously, for us, you know, so many of our Medicare beneficiaries get taken care of and get treated and rely on those critical access hospitals, and the economics of health care in rural America is different than it is in other places. And that is both a short-term issue that we have regulations, as you know, to set and deal with, but it is also a longer term question around how those hospitals are structured, what they provide, and how we support them in the appropriate way.

Mr. SMITH OF NEBRASKA. Okay. In your response to the Chairman, you had mentioned a reporting exemption for small providers. At the same time I have heard questions from those who fall below the reporting threshold who would like to be able to report data. Will they have that opportunity?

Mr. SLAVITT. So it is interesting you say that. I had that feedback last night when—in talking to a specialty society who said we want our specialty to be more engaged in the practice of medicine with seniors. And so even our physicians, who are only seeing small amounts, want to do that.

I will tell you I heard feedback in both directions so that I think our job will be, over the comment period, to take all that in and figure out how to do the best job accommodating the most types of practices as possible.

Mr. SMITH OF NEBRASKA. Okay. Well, I appreciate that. I know that the providers I talked to are constantly not just saying what the problem is but providing solutions and innovations, and I would hope that we can empower providers to care for their patients without the government getting in the way or messing things up.

Thank you, Mr. Chairman. I yield back.

Chairman TIBERI. Thank you. The former mayor of Paterson, New Jersey, Mr. Pascrell, is recognized for 5 minutes.

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

Administrator Slavitt, under your leadership, CMS has stressed the importance of better data to improve quality, to improve outcomes, and has made great strides in making that data available.

MACRA included a provision that allows innovators to use QE data, to help us make smarter decisions. Do you agree that the medical devices used in care—and I will focus in on that—particularly for the most common Medicare procedure, joint replacements, play a role in healthcare quality and outcomes?

Medicare has no information on the medical devices implanted in Medicare beneficiaries. I think we should let that settle in for a few seconds. Extremely problematic, I think, from an oversight perspective, and most importantly, from a safety perspective. You and I have had discussions, there is a history here that we need to address.

So shouldn't this information be made available?

Mr. SLAVITT. Yeah.

Mr. PASCRELL. Administrator.

Mr. SLAVITT. Thank you, Congressman.

So the question you raise is really one of—should there be, and how should we capture, a device identifier in a unique way on every device, and I think that is the goal. It is a goal that we share. It is a goal that the FDA shares. And it is critical for post-market

surveillance to be able to understand the safety of how these devices work.

So there are several, I think, critical things that we can do, and are doing, and are trying to do to make this possible. So despite our enthusiasm for this—and this is an issue that has long preceded me. As you know, it has been an issue for quite some time—there are a number of parties who have a say in the matter of how this happens.

I think as a first step, we are moving forward with the incorporation of a unique device identifier into electronic health records. I think this is a strong step, particularly considering the dramatic growth in electronic health records. But I know that there is also an interest on claim forms that there is a way for providers who provide care to indicate the device identifier on the claim form. We think that also has merit, particularly from a research perspective.

I think there are a couple of issues to making that a reality: One is the Committee that essentially designs the claim form, which is made up of a wide group of participants and hospitals and physician groups; second, is making sure that if we at CMS are given the charge to do this that we can fund it and have the funds to do it operationally; and then third, there will be an education and training process because the history is that physicians don't automatically put the information they need to down on a form unless it is critical to them getting paid.

So I think we need to work through all of these issues with you. We have pledged to do this with your office, and we are working closely with the FDA to find the best path forward.

Mr. PASCRELL. I think you have used the best word, "critical." But if we don't do it this time, then we have to wait another 15 years before we change those forms, and our seniors will not be well served. This is important. I have been frustrated with CMS' resistance to what I believe is a very important priority, particularly of safety, including the unique device identifiers on health insurance claims.

In order for the UDI to be added to the claims form as part of the next update, it would go into effect, I think, in 2021. That is the soonest. We need to act now, and I think—I can't stress enough, Mr. Chairman, we are talking about the safety of the people who use these devices, and we all want to be on the same page. This is, I think, a good time for us to address this issue.

A number of cases, a number of anecdotal stories about not only seniors, by the way, but—we talked about seniors here because we are talking about Medicare—people that have had the problems, and we need to address that in order to improve safety. Everybody on this Committee talks about it, and I believe them and their hearts. Here is a chance for us to do something about it.

But I want to thank you, Mr. Slavitt. You have done a great job and thank you for putting up with us, but we are not going away. Thank you.

Mr. SLAVITT. Thank you, Congressman.

Chairman TIBERI. Thank you, Mr. Pascrell.

Ms. Jenkins is recognized for 5 minutes.

Ms. JENKINS. Thank you, Mr. Chairman.

Thank you, Mr. Administrator, for joining us today.

Medicare obviously plays an important role for many Kansans. It is the largest payer for medical services in America, a lifesaving benefit for many people. Last year, over 485,000 Kansans had health coverage from Medicare. We were pleased MACRA passed last year in a bipartisan manner. With the passage of MACRA we repealed SGR and instead put in place what will hopefully lead to a better reimbursement system for physicians.

Mr. Slavitt, the relationship between a physician and a beneficiary cannot be underscored in importance, and I believe this is especially true when talking about seniors. With the moves that MACRA makes toward higher-value care centered on the quality of care administered by clinicians, it is ever important to ensure that we encourage greater and greater communication around decision-making between the doctors and their patients. So as MACRA's implementation continues over the next several years, do you see room to begin including patient activation measures, placing greater responsibility on this relationship with the hopeful result of shared responsibility over healthcare maintenance and thus furthering the quality of care?

Mr. SLAVITT. Yes. Thank you, Congresswoman, for that. I think that is a really important question, and I think there is an opportunity over the next several years to begin to incorporate those engagement measures in.

There are a few things that are in the current proposal that I would point to that take steps in that direction: One is there is a practice improvement focus opportunity on the creation of a joint care plan between a patient and a physician; second, in the advancing care information area, there are opportunities that focus on measures around how patients and physicians are communicating using technology and making sure that information is being made available to patients electronically and through other means.

But I think this is, as you point out, a ripe opportunity and a brand new area of focus for more patient engagement. We have been meeting with a number of patient groups as we have been putting this work together, and that is an important area of feedback for us.

Ms. JENKINS. All right. Thank you, Mr. Chairman. I yield back.

Chairman TIBERI. Thank you.

Mr. Davis is recognized for 5 minutes.

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

Let me welcome you, Mr. Slavitt. I know that you have spent considerable growing-up time in Evanston, Illinois, which isn't very far from my district. And I also know that your mother lives in my district, and I am pleased to tell you that I have not had any real complaints from her, and so that makes me feel good.

Mr. SLAVITT. That makes one of us.

Mr. DAVIS. But let me compliment you on your work. Medicine is a very complex environment, and there is tremendous complexity. And I also want to thank your staff. I have 24 hospitals in my district, four large medical schools, a number of research institutions, and a very activated citizenry. So we get lots of inquiries, lots of calls for assistance, a lot of calls for clarification. And so we spend considerable time not pestering but certainly inquiring

of your staff, and I want to thank them for the kinds of sensitivities they have displayed.

I also have a very active medical community, physicians associations and organizations. Just last week I had a meeting with the Chicago Medical Society. But I have heard concerns that under the proposed rule that we are talking about, only a limited number of physicians will meet the alternative payment model, or APM, criteria to earn the payment bonus.

By your own estimation, you have indicated that there may be only 30,000 to 90,000 physicians who meet these terms, which is a tiny fraction of the total Medicare-eligible doctors in the country, and I am certain that we will hear some more from these physician groups. They would like to know what could make it—or how likely is it that anything will make it easier for there to be more pathways to qualify for the APM bonus payments?

And how can CMS improve the opportunities for our physicians to meet the advanced APM criteria, and achieve the incentive to drive better care that Congress intended?

And would you consider additional pathways that qualify as advanced APMs to provide assistance for our physicians who wish to enter the current model?

Mr. SLAVITT. Thank you, Congressman. And my mother made me promise to tell you that she was a teacher at Howe and working with Principal Pat Tyco (ph), she knows you well and so she made sure I said this publicly. So I have delivered that for my mother.

Mr. DAVIS. Thank you.

Mr. SLAVITT. And your question is an important question because all physicians who participate in the Medicare program are going to have a significant opportunity to get rewarded and get paid for providing quality medicine, which is exactly what we hear from physicians that they want. Some physicians will have the opportunity to go further, and I think the law allows those physicians to get a 5 percent bonus if they participate in these advanced payment models.

So our goal is not just to make the core program good but to create as many opportunities for physicians as possible to move into these programs, and we can do that in a number of ways. One of the important ways to do that is to simply create more models and more opportunities. We also have to make it easy for people to move back and forth if they choose to between programs, and I think that is one of the things that we are striving to achieve.

And then, as we talked about earlier with Dr. Price, we also have to look at—are there ways we can take existing models and make them compliant with this new law? So we are going to work on all three of those avenues because it is a goal for any physician that wants to move to one of these advanced APM or care coordination models that they have the opportunity to do so.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Chairman TIBERI. Former Mayor Marchant of Texas is recognized for 5 minutes.

Mr. MARCHANT. Thank you, Mr. Chairman.

Mr. Slavitt, does the CMS have the resources to approve and implement the new alternative payment model proposals in a timely manner?

Mr. SLAVITT. Yes. Thank you.

I believe the question is can we implement new models in a timely manner, and one of the things that we have to do—and the answer is yes, we can. We need to, in concert with the committee that was set up by the Congress, the PTAC, we need to receive proposals from physicians because physicians can generate their own proposals for models and quality and then work with them to, as rapidly as possible, test them and put them into action.

It is one of the things that we have had the opportunity to work on over the last 6 or 7 years through the innovation center. It is something that we have gotten better and better at, and we are eager to get going with this Committee to get as many models in as possible so that we can get more and more models approved. And I had a chance to speak with that committee and speak in front of that committee to try to encourage more model development.

Mr. MARCHANT. And there is a deadline period, so you are confident that you can get all that done by the deadline?

Mr. SLAVITT. Well, fortunately, this is something that will be ongoing, so as soon as we get models in we can get them tested. But this committee, I believe, will be standing for a number of years. I am not sure if I know the exact number of years, but it will be ongoing because physicians will be able to continue to develop new models.

Mr. MARCHANT. So the transition in governments that is coming up won't have any affect on this process?

Mr. SLAVITT. No. The staff at CMS will work with the new secretary, whoever that is, and continue moving that forward very much with that, and I think there is—as I have heard today and as I think we continue to hear—there is strong bipartisan commitment and a strong commitment to this program in moving this forward, so I don't see any concerns at this point.

Mr. MARCHANT. And just some input in my district, I hear from two different groups, and this is concerning the new program where you basically are—let's say, a knee replacement or a hip replacement, you are basically going to fund a lump sum for that. I am hearing from seniors who think that the doctors and hospitals are going to cut corners so that they will make the most amount of profit and just hurry them through the system. And then I am hearing from the doctors and the hospitals who are afraid that they are not going to get enough money to take the kind of care of their patients that they need to take care of them.

So I guess you have created a pretty positive—these two tensions that are working out there, could you just make a comment about that?

Mr. SLAVITT. Sure. I think what you are referring to is a new type of payment approach, new for Medicare but it has been ongoing in health care for a long time, called the bundled payment.

Mr. MARCHANT. Yeah.

Mr. SLAVITT. And really the idea behind the bundled payment is so that people—everyone who is involved in the patient care,

whether it is before they would have a surgery, the surgeon, the anesthesiologist, but also the people that take care of the patient afterwards, have an alignment to get on the same page to provide a high-quality outcome and to do it as a team.

And so it is relatively new to Medicare. We have had good experience and good feedback so far. But as with anything new, we continue to look for feedback, for data, for our experiences, and in particular, if there are beneficiaries in your district or hospitals or physicians in your district that have experience with the program, we would love to get feedback for them from you or your staff.

Mr. MARCHANT. Well, the group that I hear from the most is the in-home healthcare people, who feel like they are kind of at the tail end of the process and that they may be the ones—and they feel like they are the most cost effective of all, yet they feel like at the end of that process there may be some shortchanging going on.

Mr. SLAVITT. Thank you.

Mr. MARCHANT. Okay. Thank you.

Chairman TIBERI. Thank you.

Mr. Lewis is recognized for 5 minutes.

Mr. LEWIS. Thank you very much, Mr. Chairman, for holding this hearing today.

Mr. Administrator, thank you for being with us. Thank you for all your great and good work.

Can you talk more about what people on Medicare might experience as a result of this change of payment policy, how smaller provider groups would be impacted and the doctors who need help to get up to speed?

Mr. SLAVITT. Thank you.

I think the most important thing that we have an opportunity to focus on here is patient care and improving patient care. And I think the ways to do so are severalfold: First, is this new legislation allows us to pay physicians more for providing higher-quality care, and the objective is to do this in a way which allows the physician to define what they believe to be the highest quality care from a menu of options and reward them for achieving those benchmarks. And I think physicians have been asking for that in one form or another for quite some time.

Second, though, it is important to do that in a way that frees up physicians to actually practice medicine instead of just keeping score. And too many programs result in a lot of paperwork and a lot of scorekeeping and a lot of reporting, and we need to minimize that by simplifying wherever possible.

The role of small physician practices, which you also mentioned, is critical here. And as we mentioned earlier, we believe that small, solo, and solo practitioners have every opportunity to be just as successful as larger size practices, and our data suggests that that indeed happens so long as the smaller practices report. So that means we need to minimize paperwork.

We have also put in place some accommodations for smaller practices, including some technical assistance, some additional models, and ways that they can get excluded from reporting if their volumes are too low.

Mr. LEWIS. Thank you.

Furthermore, Mr. Administrator, this is a very large regulation, over 900 pages. It is pretty big. It is a lot to digest, a lot to understand. If you had to tell your doctor the highlights of these changes, what would you tell her, what would your doctor need to know to maximize benefits and avoid payment cuts?

Mr. SLAVITT. Great. That is a great question, and it may be one of the most important things that I can communicate today.

First of all, it is key focusing on patient care. There is nothing in here that should distract anybody from patient care, and, in fact, it will make it easier by streamlining a patchwork of programs that are already out there today into something simpler. So that is first.

Second is they will have the opportunity to select goals that they believe are right for their practice and right for their patient population, and at some point in time they will have an opportunity to do that.

Third, I think, would be that over time there will be opportunities for them to participate in more advanced models, like the kinds you asked me about earlier.

Fourth, is they don't need to really worry about reporting anything until spring of 2018, and we will make it clear what needs to be done well before then.

And then finally, the last thing, and this is more my asking of them, is to provide feedback to this rule, whether it is through the medical society they belong to, the State medical society, or directly to us. We really need line physicians who are practicing medicine every day to give us their feedback on what works about this rule and what might be the unintended consequences.

Mr. LEWIS. Thank you very much. And again, I appreciate your effort, your great and good work, and thank you for being willing to serve.

Mr. SLAVITT. Thank you.

Mr. LEWIS. Mr. Chairman, I yield back.

Chairman TIBERI. Thank you, Mr. Lewis.

Mr. Paulsen is recognized for 5 minutes.

Mr. PAULSEN. Thank you, Mr. Chairman.

And Mr. Slavitt, it is great to see you here today—welcome—rather than on an airplane going back and forth to Minnesota.

As has already been said, you know, last year both sides took very historic action to move forward to finally get rid of the flawed Medicare payment formula based on the SGR and we wonder if we are going to fix it every 6 months or every year. And like any law, passage is just the first step, right? It is the implementation that has to be carried out and followed through, making sure it is done correctly so that we are achieving the intended results.

I just want to thank you at the outset for working with physicians, working with patients, having that connecting dialogue with all the appropriate stakeholders, including Members of the Committee, to make sure that we are implementing it in the correct fashion.

I do want to continue on the comment theme and just mention at the outset that it is important to know that I continue to hear from folks back in Minnesota as well that aren't in large, integrated practices, solo practices, small group practices, et cetera, that do have that concern. And as you mentioned, you want to

make sure that they have every opportunity to participate. And I think they want that reassurance and we just kind of need to keep monitoring that going forward. I thank you for that.

Let me ask you this question: I have also heard from a lot of physicians and doctors in Minnesota about the meaningful-use program for electronic healthcare records and how it doesn't do a very good job of taking into account the way physicians treat patients and use their electronic healthcare records. Is this rule the same-old, same-old, or do you make real changes in how you are going to be encouraging doctors now to actually use their electronic healthcare records?

Mr. SLAVITT. Thank you, Congressman. And I would agree that our district practices some of the best medicine.

The meaningful-use program is something that we took an extremely hard look at. We took a step back, because the meaningful-use program actually is responsible for helping to make technology pervasive in medicine, and that is a very good thing. If we look back 5 or 6 years ago, most physician offices, most hospitals didn't have adequate information technology. Today, by and large, 97 percent of hospitals, 70 percent of physician practices have technology.

But as we look at how to go forward, we spend a lot of time talking to physicians and hearing exactly what you said, Congressman, which is that the meaningful-use program was focusing on making sure they were using their computers and not focusing on taking care of patients.

We also heard that physicians want their technology to be more connected. They want to be able to get information back and forth from other physicians when they refer patients or from hospitals, and they are also frustrated that there isn't enough connectivity and the data doesn't flow as easily as it should.

And so we have been asked to focus on it, and I believe have focused on, in this rule, changing the program so it becomes much more flexible, moves the focus to the patient and away from the use of the technology, focuses on the interaction and communication, and allowing the free flow of data to move back and forth. And those are the areas that we emphasize we look forward to comments on during the comment period about whether or not we have done that well.

Mr. PAULSEN. Does it seem like the proposed rule, replacing meaningful-use with this new category, advancing care information, right, we have all these different acronyms, but accounting for 25 percent of a physician's performance score in the first year, is that going to essentially be interoperability now for electronic healthcare information for venders, for hospitals, for all the different actors and players, physicians and other providers? Is that the intent that this information is going to be that widely shared, that readily available, not just being on the computer but actually using information?

Mr. SLAVITT. Right. That is the intent. I would say everybody has a job to do in that regard. If any of us here could wave our magic wand and make the healthcare system more interoperable, I think we would do it. But this really requires vendors to share data to publish to what they call open APIs, to not practice what we talk about is data blocking, which the Congress has expressly

asked that vendors not do, and physicians, to a large extent are really a victim of what the technology allows.

They all want to share data. I have not met a physician who when they refer a patient doesn't want to know what happened to that patient and get that back electronically. But it is the technology that really needs to do that job. We think in the EHR certification that just came out and in a number of the other activities, we think vendors are going to move in that direction. They need to move in that direction.

Mr. PAULSEN. Thank you, Mr. Chairman. I appreciate it. I yield back.

Chairman TIBERI. Thank you, Mr. Paulsen.

Thank you, Mr. Slavitt.

One comment related to that is—we can discuss this more—as you develop a final rule and the performance period begins on January of 2017, vendors are going to have a limited time to reconcile with this new rule and then physicians are going to have to digest the new rule. So, you know, I hope that, again, particularly for the small group rural markets, I hope that you will work with us to make sure that that implementation is done smoothly.

And related to that, I don't know if you think you have some authority in this area, but the gap of time between performance period and then the payment here for physicians is 2 years, yet the clinician reporting period is a shorter period of time. Do you think CMS has the ability, the rulemaking, the authority to change that a little bit?

Mr. SLAVITT. Yep. So one of the things that we do see comment on are the proposed measurement periods and payment periods. What I will say is a couple things: One is, we have two feedback periods built in so that—one in the middle of 2017 and one in the middle of 2018, to provide information back to physicians. So there is a more current feedback loop.

The second thing I would say is because we have focused so much on reducing burden and reducing the number of measures and so forth, that is—we have had some feedback that people want to make sure that that starts as early as possible. We have had other feedback, of course, which tells us make sure we have enough time, make sure we have enough time to do the things we need to do, make sure we don't get penalized unnecessarily because we didn't have enough time.

And to your earlier question, Mr. Chairman, if people will begin on the older technology and move to the newer technology, they will not get penalized for that. So we are making those accommodations. But of course, the purpose of the comment period is for people to tell us what are the things we missed, what are the things that could have an impact on someone's practice or on their patients that we didn't think of.

And that is one of the reasons why, if there is an important message today to get out, it is to please engage in the rule and give us the feedback that we need to hear.

Chairman TIBERI. Well, I can't thank you enough for coming today. As you can tell, in a bipartisan way, Members have a lot of interest in this and not just at the Subcommittee level but the Committee as a whole, as well as the Congress.

And we really appreciate you taking the time and look forward to working with you and your team as you continue to develop this and ultimately put it into practice the way that we all intended it to be. And I appreciate the fact that you were so kind yesterday as well.

I look forward to working with you. Hopefully we have treated you nice enough that you will come back, as we have this bipartisan concern about the way this unfolds.

So as a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any Members submit questions after the hearing, I ask that the witnesses respond in writing in a timely manner.

With that, again, thank you and this Subcommittee is adjourned.

[Whereupon, at 3:36 p.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]

Andy Slavitt, Acting Administrator, CMS
"Implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)"
Before the
Committee on Ways & Means, Subcommittee on Health

May 11, 2016

Additional Questions for the Record

From Representative George Holding of North Carolina:

As you know, the MACRA statute provides for bonus payments to health professionals who participate in certain Alternative Payment Models (APMs), which MACRA refers to as "eligible" APMs.

To be "eligible," (1) health professionals in the APM must use Certified Electronic-Health-Records (EHR) Technology; (2) the APM must make payments to the health professionals on the basis of Quality Measures; and (3) the APM must bear financial risk for monetary losses that are in excess of a nominal amount.

I note that, in the MACRA proposed rule, CMS has expressly decided that a particular type of APM—the Bundled Payment for Care Improvement (BPCI) Model—is not an eligible APM.

The BPCI APM Model was developed by the Center for Medicare and Medicaid Innovation (CMMI). In this type of APM, payments are linked to patients' particular episodes of care, and the APM is responsible for financial losses. The goal is to provide higher quality and more coordinated care at a lower cost to Medicare.

The BPCI APM Model has been successful.

1. **What is the logical and legal basis for CMS to decide that the BPCI APM Model is not an eligible APM? This type of APM bears the financial risk of monetary losses; it participates in all applicable CMS Quality Measures; and the majority of its health professionals use Certified EHR Technology.**

2. **Why did the agency decide not to use the statutory term "eligible" APM but to instead create the term "Advanced" APM for use in the MACRA proposed rule?**

Answer: In the proposed rule, we have proposed the term "Advanced APM" for those APMs defined by section 1833(z)(3)(C) of the Act that meet the criteria under section 1833(z)(3)(D) of the Act. The statute indirectly defines the term "eligible APM" as the APMs in which "eligible alternative payment entities" participate. We decided to use the term "Advanced" in lieu of "Eligible" for those APMs meeting the criteria under section 1833(z)(3)(D) of the Act. Rather

than referring indirectly to the APM in which an eligible alternative payment entity participates, we believe it is essential to the understanding of the proposed rule to be able to identify and propose requirements directly for an Advanced APM.

3. **Does the decision to refer to "Advanced" APMs and to exclude a worthy APM such as the BPCI APM Model demonstrate that CMS has moved the bar beyond the parameters of the MACRA statute?**

Answer to 1 & 3: To qualify as an Advanced APM, we proposed that an APM must meet three criteria specified in the statute. The APM must:

- Require participants to use certified EHR technology
- Provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS
- Require that participating APM entities bear risk for monetary losses of more than a nominal amount or be a Medical Home Model expanded under CMMI authority.

While the BPCI Models 2. 3, and 4 would meet the proposed financial risk criterion for Advanced APMs, they do not require participants to use certified electronic health record technology or incorporate quality measure results as a factor when determining payment to participants, as required by statutory criteria. In addition, in our proposed rule, we specifically sought feedback on how we might change the design of the Comprehensive Care for Joint Replacement (CJR) model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs. We look forward to receiving and reviewing comments from stakeholders.

Working within the confines of the statute, CMS is currently engaged in efforts to examine our existing APMs and see where alterations can be made to the design of those initiatives that both satisfy obligations to current model participants and allow participants to qualify for the Advanced APM incentive payments. The proposed rule is only the first step of an iterative implementation process, and CMS looks forward to comments and feedback on the proposed rule.

From Representative Tom Price of Georgia:

Serious Challenges with Timing of Reporting

1. **The proposed MACRA rule states that physicians would only receive performance feedback on quality and resource use on an annual basis. Physicians have asked for more timely access to data. What steps has CMS taken to improve its systems so that physicians can get data on a timely basis?**

2. **Congress told CMS in MACRA (Social Security Act Sec. 1848(q)(4)) that the MIPS performance period "shall begin and end prior to the beginning of [the payment year]** *and be as close as possible* **to such year" (emphasis added). In your proposed rule CMS**

proposes that the performance period begin on Jan. 1, 2017, fully two years before the first day of payment adjustments under MIPS – which is on Jan. 1, 2019. We now have experience with a 2-year delay between performance and payment in the other value-based programs (MU, PQRS, and VBM), and we know that physicians find a 2-year gap between performance and payment to be very frustrating. How can CMS reduce the gap between performance and payment, in accordance with Congress's intent?

Answer 1 & 2: CMS works continuously to gather feedback from physicians, and we have heard that physicians generally want a one year performance period and an additional three to four months to finish reporting. Physicians expressed concerns that a shorter performance period could potentially mean less mature claims, a less accurate portrayal of physician activities, or less time for physicians to review data. In order to allow clinicians a full year performance period, adequate reporting time for clinicians, and adequate time for CMS to analyze the data before implementing the MIPS payment adjustment as mandated in the year 2019, CMS has proposed to establish calendar year 2017 as the first performance period. However, the majority of clinicians would not need to begin submitting data until 2018, and they would be given several months to fulfill these requirements.

CMS understands that being prepared for the changes brought by MIPS implementation is critically important for clinicians. When it comes to reporting their performance, clinicians have many options under the proposed rule. For those already participating in the Physician Quality Reporting System (PQRS), they are able to continue to report using one of the methods to which they are accustomed, such as through data registries or directly from their EHR. Clinicians who are new to reporting can also take advantage of these options to report their data.
CMS is committed to working with clinicians, medical societies and other stakeholders on resources to help clinicians pick the approach that will best meet their individual needs. For example, clinicians using registries for reporting may be able to work with those registries to receive more frequent feedback on their performance. Congress also included resources for technical assistance to help practices meet these challenges. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed performance period.

Impact on Small/Solo Practices

3. **Under the proposed MACRA rule, physician practices with Medicare charges of less than or equal to $10,000 and 100 or fewer Part B-enrolled Medicare beneficiaries under their care are exempt from MIPS. Would CMS consider raising the threshold to ensure that small and solo practices are not unfairly targeted for payment cuts?**

Answer: In our proposed rule, we define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. We believe this strategy is value-oriented as it retains as MIPS eligible clinicians those clinicians who are treating relatively few

beneficiaries, but engage in resource-intensive specialties, or those treating many beneficiaries with relatively low-priced services. By requiring both criteria be met, we can meaningfully measure the performance and drive quality improvement across the broadest range of MIPS eligible clinician types and specialties. Conversely, it excludes MIPS eligible clinicians who do not have a substantial quantity of interactions with Medicare beneficiaries or furnish high cost services. We plan to monitor the proposed requirement and anticipate that the specific thresholds will evolve over time. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including on how we could potentially differently define these thresholds in a way that accomplishes our goals.

4. **In 2019, when the payment adjustments under MIPS are first implemented, CMS estimates that 87 percent of solo practitioners will face penalties totaling $300 million. Practices with two to nine physicians will face penalties of $279 million. What is CMS doing to prevent further consolidation within healthcare as a result of this rule. Additionally, how does CMS plan to address the problem of small and solo practices being disproportionately penalized in the final rule?**

Answer: Small practices (typically defined as 15 or fewer clinicians) and practices in rural or health professions shortage areas play a vital role in the care of Medicare patients with diverse needs. CMS is sensitive to the unique challenges that small practices face in different types of communities, and the policies proposed under the Quality Payment Program would accommodate various practice sizes and configurations. In addition, CMS is sensitive to the concerns expressed in response to the proposed rule's regulatory impact analysis, which was perceived to show that the Quality Payment Program would negatively impact small practices. This regulatory impact analysis is based on 2014 data when many small and solo practice physicians did not report performance on PQRS measures. It also does not reflect the policies in the proposed rule that are intended to provide additional flexibility to various practice sizes and configurations. CMS is committed to a continued dialogue regarding the obstacles and challenges these practices encounter, both during the rulemaking period and throughout the implementation of the Quality Payment Program.

APMs for Specialties

5. **The performance period beginning in 2017 means that very few specialists will have access to APMs prior to the expiration of the APM incentives. Clinicians will be eligible for a 5% payment bonus under APMs from 2019-2024. Does CMS have the resources to approve/implement new specialty APM proposals in a timeframe to meet the deadline for the incentive period?**

Answer: CMS appreciates that many clinicians, including specialists, are eager for opportunities to participate in Advanced APMs. Working within the confines of the statute, CMS is currently engaged in efforts to examine our existing APMs and see where alterations can be made to the design of those initiatives that both satisfy obligations to current model participants and allow participants to qualify for the Advanced APM bonus payments. For example, in our proposal, we

requested comments on how we might change the design of the Comprehensive Care for Joint Replacement (CJR) model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs.

We also note that specialists currently participate in and can apply to join other APMs proposed to be Advanced APMs that are not specialty-specific, including Tracks 2 and 3 of the Medicare Shared Savings Program, Comprehensive End-Stage Renal Disease Care Initiative (Large Dialysis Organization arrangement), and the Next Generation Accountable Care Organization Model.

6. **If CMS doesn't have the resources to consider physician-focused payment model (PFPM) from the PTAC, then why is CMS expending additional resources through CMMI in developing their own advanced APMs?**

7. **What plans does CMS have to utilize CMMI in the development of Advanced APMs and will physicians or the PTAC be consulted prior to the rollout of new CMMI advanced APMs.**

Answer 6 & 7: CMS agrees that it is important for physicians to be able to participate in Advanced APMs. To help spur innovation for models that meet the needs of the physician community, MACRA established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will meet at least a quarterly to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The eleven members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. CMS looks forward to receiving these critical recommendations for new physician-focused payment models. We encourage physician specialists and other stakeholders to engage with the PTAC to suggest well designed, robust models. We are committed to working closely with the PTAC and are looking forward to reviewing their recommendations.

Outreach and collaboration are a critical part of our work to expand participation in Advanced APMs, and CMS looks forward to the opportunity to apply the experience of the Innovation Center during our review of recommended PTAC models.

In addition, CMS's Center for Medicare and Medicaid Innovation (Innovation Center) is actively seeking ideas from the public, including specialty physicians and societies, on how care can be delivered and paid for in ways that will lower the total costs while improving quality. Ideas may be submitted by visiting our website[1] https://innovation.cms.gov/Share-Your-Ideas/index.html.

8. **Going forward, what plans does CMS have to work with and, where appropriate, provide assistance to physicians to ensure that all physicians will have every**

[1] https://innovation.cms.gov/Share-Your-Ideas/index.html

opportunity to create alternative payment models which fit their unique specialty, practices and patients?

Answer: CMS looks forward to receiving recommendations from the PTAC for new physician-focused payment models. In the proposed rule, we propose criteria for the PTAC to use in making recommendations for physician-focused payment models. We also published in the proposed rule a list of factors CMS typically uses in the selection of models for testing (https://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf). In order to facilitate and potentially expedite the consideration of models for testing by CMS following PTAC review and recommendation, we also identified "supplemental information elements" stakeholders may include in their physician-focused payment models proposals to assist with model review.

In addition, CMS's Center for Medicare and Medicaid Innovation (Innovation Center) is actively seeking ideas from the public, including specialty physicians and societies, on how care can be delivered and paid for in ways that will lower the total costs while improving quality. Ideas may be submitted by visiting our website: https://innovation.cms.gov/Share-Your-Ideas/index.html.

We know that physicians and other clinicians may need assistance in transitioning to the MIPS, and we want to make sure that they have the tools they need to succeed in a redesigned system. Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas. This will be accomplished through national, regional and local activities such as webinars, national associations, Open Door Forums and continuing medical education.

In addition, CMS awarded $685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely through the Transforming Clinical Practice Initiative, which is designed to help clinicians achieve large-scale health transformation.

MIPS Generally

9. **A Washington Post article released last week (dated May 3, 2016) stated that medical errors in healthcare facilities are now the third leading cause of death in the United States, claiming more lives than respiratory disease, accidents, stroke, and Alzheimer's. Is it possible that excessive quality reporting may have an adverse effect on patient care**

Answer: We recognize the need to address medical errors in healthcare facilities. We have targeted efforts at patient safety in recent years, with successful initiatives to reduce healthcare-associated infections and hospital acquired conditions. These have included the Partnership for Patients (PfP) initiative, as well as work of the Quality Improvement Organizations. The work of the Hospital Engagement Networks in the PfP, for example, has targeted a specific set of hospital-acquired conditions through public-private partnerships, the spread of best practices, and

systematic quality improvement work. We are already seeing national trends in health care improvements that are promising and likely a combined result of our efforts:

- Interim estimates for 2014 show a sustained 17 percent decline in hospital-acquired conditions, such as pressure ulcers, infections, and avoidable traumas, since 2010, representing over 87,000 lives saved and nearly $20 billion in health care cost savings.[2]
- Between April 2010 and May 2015, an estimated 565,000 readmissions were prevented across all conditions, compared to the readmission rate in the year prior to the passage of the Affordable Care Act (April 2009 to March 2010). That is 565,000 times that a patient didn't have to experience an extra hospital stay.[3]

Quality reporting is critical both to gauge progress and to incentivize improvement. Reporting should not be excessive or burdensome, but should allow clinicians and providers to focus on areas that are directly relevant to treatment of their patients and provide them valuable information. We recognize the need to continue to prioritize the area of patient safety in the coming years. The recently released draft Measure Development Plan includes the area of patient safety as among those prioritized measure gap areas identified by stakeholders. In addition, in the proposed rule, patient safety measures are defined as high priority measures under MIPS.

CMS has worked with America's Health Insurance Plans, commercial payers, and a broad collaborative of health care system participants (known as the Core Quality Measures Collaborative) to establish core measures for physician quality programs. The goal of this effort is to establish broadly agreed upon core measure sets that could be harmonized across both commercial and government payers, which will add focus to quality improvement efforts, reduce the reporting burden of quality measures, and offer consumers actionable information for decision-making.

We believe that the proposed streamlined and focused reporting under the Quality Payment Program, as well as the future development of patient safety evidence-based measures, will assist with and add to our efforts to continue to make progress in this challenging but critically important area.

10. Under MIPS, doctors will receive payment adjustments based on the scores they achieve relative to other providers. To me, this is a lot like the situation where a professor tells a class that he will only give 5 students "As", regardless of whether or not you score above 90%. Is this the fairest way to incentivize doctors to accept this program, particularly when physicians are unable to fully control their ability to avoid a penalty?

Answer: The statute requires that payment adjustment factors be applied on a linear sliding scale for both upward and downward adjustments. The statute also includes a requirement for budget neutrality, under which, subject to certain limited exceptions, the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors is

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[2] http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html
[3] http://www.hhs.gov/blog/2016/02/24/reducing-avoidable-hospital-readmissions.html

equal to the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors.

While aligning with these statutory provisions, we propose a scoring methodology that allows for accountability and alignment across the performance categories and minimizes burden on MIPS eligible clinicians. Further, we propose a scoring methodology that is meaningful, understandable and flexible for all MIPS eligible clinicians. Our proposed methodology allows for multiple pathways to success with flexibility for the variety of practice types and reporting options. First, we have proposed multiple ways that MIPS eligible clinicians may submit data to MIPS for the quality performance category. Second, we generally do not propose "all-or-nothing" reporting requirements for MIPS. Third, bonus points would be available for reporting high priority measures and electronic reporting of quality data. Under our proposed rule, clinicians who are subject to MIPS payment adjustments have opportunities to succeed. CMS intends to publicly announce the benchmarks for this program in advance so clinicians have time to prepare their practices. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed scoring methodology.

The New Meaningful Use: Advancing Care Information

11. The ACI program takes the Meaningful Use Stage 3 measures and simply establishes new mechanisms for calculating a physician's successful participation. This is not a major overhaul of the program and it will not encourage software vendors to improve the usability and interoperability their systems. Consequently, for the foreseeable future, physicians are going to spend more time checking boxes than delivering patient care. How does the agency intend to make good on your CMS's promise to overhauling this dysfunctional program?

12. The ACI program makes up 25% of the total MIPS score; however, despite promises of fixing the burdensome MU program, it appears that ACI is even more complicated than MU. For example, I understand that if providers don't satisfy all of the requirements for the base score, they will receive a zero, which will cause them to receive payment cuts under MIPS. While the performance score does offer some flexibility, there is room to make the program more workable. Looking ahead, what steps is CMS taking to ensure that there will be more flexibility within ACI, opposed to the current EHR meaningful use efforts?

Answer 11 & 12: As we considered all the input we received from thousands of stakeholders across the country during development of the proposed rule, it created a clear blueprint for how we proposed to go forward to replace Meaningful Use for Medicare providers with a more flexible, outcome-oriented and less burdensome proposal. The implementation of the advancing care information performance category is an important opportunity to increase clinician and patient engagement, improve the use of health IT to achieve better patient outcomes, and continue to meet the vision of enhancing the use of certified EHR technology.

In our proposed rule, we address these critical issues by proposing to eliminate measurements that are overly burdensome or redundant, allowing technology to focus on interoperability and be flexible enough to fit into the clinical workflow. We proposed a more flexible evaluation and removed some threshold requirements, lowering the burden on providers. We also proposed that clinicians could = report as a group, as well as multiple paths available to clinicians to achieve the maximum score for this category. There would be an all-time low of eleven measures, down from eighteen measures in the current EHR Incentive program. Compared to the existing Medicare EHR Incentive program, the new approach increases flexibility, focuses on interoperability, and reduces burden. We are dedicated to ensuring technology is a meaningful tool that provides real value for clinicians.

These improvements increase program flexibility and support the advancement of innovative technology that can meet the needs of providers and the patients they serve. For example, we are requiring open application programming interfaces in newly certified technology so the clinician desktop is opened up to allow apps, analytic tools, and medical devices to plug and play. We urge developers to take advantage of the flexibility to design around the everyday needs of the users, rather than designing to a one size fits all approach. Already, developers that provide over 90 percent of electronic health records used by U.S. hospitals have made public commitments to make it easier for individuals to access their own data; not block information; and speak the same language.[4] The provisions in the proposed rule are a critical step in support of these efforts to achieve true interoperability of health information. However, the proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed approach to Advancing Care Information.

13. The 8 performance measures under ACI require extremely challenging patient engagement measures, which physicians have continually expressed concerns about their practicality. For example, the secure messaging measure requires that physicians either send a secure electronic message or reply to a secure electronic message to 100% of their patients to achieve 100% of the measure rather than the 5% threshold that was originally required in Stage 2 of Meaningful Use. Given that the lower threshold under Stage 2 was too high for most physicians to achieve, what was the rationale for setting the 100% threshold in ACI? If most physicians were unable to attest to a much lower threshold under Stage 2, how will physicians be able to meet the new required 100% threshold?

Answer: CMS recognizes the potential benefits and challenges to adopting and implementing new applications of certified health information technology – including secure messaging. We have received feedback from physicians and other stakeholders that some patients are unable or reluctant to send secure messages due to data breach fears, lack of internet familiarity, and overall lack of access. As a result, CMS modified the Secure Messaging measure in the Medicare and Medicaid Programs: Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017 Final Rule. The rule changed the Secure Messaging measure threshold for the Medicare EHR Incentive Program in 2015 to enable the capability to

[4] http://www.hhs.gov/about/news/2016/02/29/hhs-announces-major-commitments-healthcare-industry-make-electronic-health-records-work-better.html

send or receive a secure electronic message. For 2016, the rule modified the threshold so that a secure message had to be sent to *at least one* patient. Said differently, eligible professionals must send a secure message to one patient to achieve the Secure Messaging measure in 2016.

Furthermore, CMS has ***not*** proposed to set a threshold of 100 percent for the Secure Messaging measure under MIPS. Rather, we have proposed that eligible clinicians will get full credit toward the "base score" of the Advancing Care Information (ACI) performance category as long as they report a numerator *of at least one* for the Secure Messaging measure as well as other measures included in the base score. More specifically, eligible clinicians that report that they have sent a secure message to at least one patient during the performance period would meet the requirements of the Secure Messaging measure and receive credit toward the ACI base score. The base score would make up 50 percent of the overall ACI performance category score.

Under the performance score – which would make up the other 50 percent of the overall ACI performance category – eligible clinicians would be able to earn additional points for performance on the objectives and eight corresponding measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. Importantly, under the proposed rule, eligible clinicians would have flexibility to focus on the measures that are right for their patients and their practice. Even though the Secure Electronic Messaging measure is one of the measures that would be included in the performance score, eligible clinicians may choose to focus on the other measures and still receive full credit for the ACI performance category.

Appeals

14. The process to appeal one's MIPS score consists of no hearing or evidence submission process, and any decision made on appeal is final and has no additional process for further review or appeal. Can you please explain the rationale for the development of such an appeals process under MIPS?

15. Without a hearing or evidence submission process, how will CMS be able to provide assurance to a physician that his or her appeal has been fairly considered?

Answer 14 & 15: MACRA requires the establishment of a process under which a MIPS eligible clinician may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such MIPS eligible clinician for a year. The statute does not require a formal appeals process and includes limits on administrative and judicial review on certain items, including the methodology used to determine the amount of the MIPS adjustment factor and the determination of the amount.

We recognize that a principled approach to requesting and conducting a targeted review is required under the MACRA in order to minimize burdens on MIPS eligible clinicians and ensure transparency under MIPS. We also believe it is important to retain the flexibility to modify MIPS eligible clinicians' composite performance score (CPS) or payment adjustment based on the

results of targeted review. This will lend confidence to the determination of the CPS and payment adjustments, as well as providing finality for the MIPS eligible clinician after the targeted review is completed. It will also minimize the need for claims reprocessing. In our proposed rule, we propose an approach that outlines the factors that we would use to determine if a targeted review may be conducted. In keeping with the statutory direction that this process be "informal," we have attempted to minimize the associated burden on the MIPS eligible clinician to the extent possible.

If a request for targeted review is approved, the outcome of such review may vary. For example, we may determine that the clinician should have been excluded from MIPS, redistribute the weights of certain performance categories within the CPS (for example, if a performance category should have been weighted at zero), or recalculate a performance category score in accordance with the scoring methodology for the affected category, if technically feasible. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed implementation of an informal review process.

Site Neutrality

16. Mr. Slavitt, do you believe that the proposed MACRA regulation is pushing physicians to move from private practice into a model where they are employed? What protections are included in the regulations that would protect the private practice physician?

Answer: A key focus in our efforts has been to reduce burden by keeping the proposed Quality Payment Program as simple as possible and providing clinicians with flexibility in meeting requirements.

We are committed to working with private practices to make sure they have the tools they need during this transition, and Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas. We are also actively seeking feedback on our proposals and on ways we could better serve the needs of small practices.

CJR: CMS Failed to Include CJR and BPCI in MACRA's Approved APMs

17. Many physicians have already invested substantial financial and structural resources in answering CMS's call to shift to existing CMMI APM models, which they have now learned may not qualify as Advanced APMs under MACRA. Why did CMS propose MACRA APM standards that many CMMI APM models do not meet?

Answer: We recognize the substantial time and money commitments in which APM participants invest in order to become successful participants. The statute creates a high bar for APMs that could be considered Advanced APMs.

To qualify as an Advanced APM, we proposed that an APM must meet three criteria specified in the statute. The APM must:

- Require participants to use certified EHR technology
- Provide payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS
- Require that participating APM entities bear risk for monetary losses of more than a nominal amount or be a Medical Home Model expanded under CMMI authority.

Working within the confines of the statute, CMS is currently engaged in efforts to examine our existing APMs and see where alterations can be made to the design of those initiatives that both satisfy obligations to current model participants and allow participants to qualify for the Advanced APM incentive payments. The proposed rule is only the first step of an iterative implementation process, and CMS looks forward to comments and feedback on the proposed rule.

18. How would MIPS incentives and penalties work for physicians participating in a mandatory bundled payment model like CJR?

Answer: We want to make sure that in addition to encouraging clinicians to improve quality of care by participating in APMs that best fit their practice and patient needs, clinicians are not subject to duplicative, overly burdensome reporting requirements. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs. In addition, in our proposed rule, we specifically sought feedback on how we might change the design of the Comprehensive Care for Joint Replacement (CJR) model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs. We look forward to receiving and reviewing comments from stakeholders.

19. How will CMS ensure that CJR/APM participants who specialize in taking on the toughest cases are not penalized?

Answer: CJR uses a specific pricing methodology for hip fracture patients due to the significantly higher spending associated with these more complex cases. CJR uses a simple risk stratification methodology to set different target prices for patients with hip fractures within each Medicare Severity-Diagnosis Related Group. We believe that this risk stratification policy addresses concerns that beneficiaries with serious conditions, acute diseases, and chronic conditions are likely to need more costly care throughout the CJR model episode because these beneficiaries are those most likely to be present in the population receiving lower extremity joint replacement procedures emergently due to a hip fracture.

20. Do CMMI and CMS plan to work together to tweak these CMMI APMs, such as CJR and BPCI, so that they will qualify as an advanced APM under MACRA?

Answer: While the Bundled Payments for Care Improvement (BPCI) Models 2, 3, and 4 would meet the proposed financial risk criterion for Advanced APMs, they do not require participants to use certified EHR electronic health record technology or incorporate quality measure results as a factor when determining payment to participants, as required by statutory criteria. In addition, in our proposed rule, we specifically sought feedback on how we might change the design of the CJR model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs. We look forward to receiving and reviewing comments from stakeholders.

Working within the confines of the statute, CMS is currently engaged in efforts to examine existing APMs established under the Innovation Center and see where refinements can be made that both satisfy obligations to current model participants and allow eligible clinician participants to qualify for the APM incentive payments.

21. Why would physicians stay in APMs that are not qualified under MACRA? Is CMS concerned that physicians participating in some of these non-qualified CMMI APMs will cease participation in these models?

Answer: Participants of certain APMs that are not considered Advanced do have advantages in the proposed MIPS scoring process For example, under the proposed rule, clinicians who participate in Advanced APMs but do not meet the law's criteria for sufficient participation in Advanced APMs, and those who participate in certain non-Advanced APMs, would be exempt from the cost category in MIPS, would be able to use their APM quality reporting for the MIPS quality category, and would receive credit toward their score in the Clinical Practice Improvement Activities category. We want to make sure that in addition to encouraging clinicians to improve quality of care by participating in APMs that best fit their practice and patient needs, clinicians are not subject to duplicate, overly burdensome reporting requirements. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule.

Private Practice Physical Therapists

22. While physical therapists (PTs) are not initially included in MIPS, the Secretary may add them or other excluded specialties to MIPS beginning in 2021. However, at this time, the factors by which additional eligible professionals will be included are unknown. Does CMS plan to include in its rulemaking this year a clear disclosure of its criteria to determine the inclusion of non-physician professionals such as physical and occupational therapists in MIPS beginning in 2021?

Answer: Physical therapists and other non-physician clinicians who are not subject to the initial MIPS payment adjustments are important parts of the health care delivery system. Currently, many of these professionals report to CMS under the Physician Quality Reporting System (PQRS), and they would have the option of continuing to report quality measures to MIPS. For individual clinicians and groups that are not initially considered MIPS eligible clinicians, such as physical therapists, but elect to report to MIPS, we would calculate all data available and issue

them a feedback report. As you noted, the statute provides the Secretary with the flexibility to specify additional eligible clinicians in the third and subsequent years of MIPS and we intend to consider using this authority to expand the definition of MIPS eligible clinicians through rulemaking in future years.

Timeline

23. Congress intended to offer physicians a period of relief spanning from 2015-2018 before making the changes necessary to implement MACRA beginning in 2019. However, under the proposed regulation, the first reporting period begins January 1, 2017, less than 7 months from now. Can you please explain why CMS moved the timeline forward to 2017 instead of 2019 as the law states?

Answer:
CMS works continuously to gather feedback from physicians, and we have heard that physicians generally want a one year performance period and an additional three to four months to finish reporting. Physicians expressed concerns that a shorter performance period could potentially mean less mature claims, a less accurate portrayal of physician activities, or less time for physicians to review data. In order to allow clinicians a full year performance period, adequate reporting time for clinicians, and adequate time for CMS to analyze the data before implementing the MIPS payment adjustment as mandated in the year 2019, CMS has proposed to establish calendar year 2017 as the first performance period. However, the majority of clinicians would not need to begin submitting data until 2018, and they would be given several months to fulfill these requirements.

CMS understands that being prepared for the changes brought by MIPS implementation is critically important for clinicians. When it comes to reporting their performance, clinicians have many options under the proposed rule. For those already participating in the PQRS, they are be able to continue to report using one of the methods to which they are accustomed, such as through data registries or directly from their EHR. Clinicians who are new to reporting can also take advantage of these options to report their data.

CMS is committed to working with clinicians, medical societies and other stakeholders on resources to help clinicians pick the approach that will best meet their individual needs. For example, clinicians using registries for reporting may be able to work with those registries to receive more frequent feedback on their performance. Congress also included resources for technical assistance to help certain practices meet these challenges. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed performance period.

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step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed performance period.

[Submissions for the Record follow:]

The Impact of IRS Activities on At Risk Citizens

The IRS was asked during a telephone conversation:
"How many citizens die each year as a result of your activities?"

The response provided was immediate and without any hesitation:
"We are not required to provide those statistics"

Analyzing this afterwards reveals telling and indicting facts.

1) This response is clearly coached and representatives indoctrinated with prepared answers.
2) The IRS is aware of the fact that citizens are dieing as a result of their activities.
3) The IRS has taken steps to block requests that they track these occurrences.
4) The IRS is not mitigating or reacting to potential at risk situations.
5) The IRS views such consequences as "collateral damage" and acceptable.

Now of course the 16th Amendment allows the government to discriminate against citizens based on their earned incoming and apply taxation accordingly. The consequences of this is the need to track citizens income and the subsequent bureaucratic burden this places. Unfortunately persons at risk due to mental health conditions and psychological behavioral patterns from birth are thereby facing additional severe discrimination that is not covered and allowed.

This 20% of the population is therefore at higher risk due to nothing more than their birth characteristics and make-up. This is not something those citizens can easily change, nor can it be simply outsourced to third party service providers to interact on their behalf, and often is associated with additional medical events in their lives, or the people around them.

For example, persons at risk of depression with introverted behaviors, their response is likely to be shutting themselves away and avoiding contact. The IRS response to that situation is unfortunately repressive, with a "guilty until proven innocent" action set including penalties, interest, asset seizure and placement of liens and levees. This can quickly become catastrophic for persons at risk.

Similarly persons with a natural distrust and rejection of authoritarian control will react to demands with discounting and ignoring. Again the quick trigger actions of the IRS to such behavior is unfortunate and then extremely hard to remediate.

But what of the IRS claim that they are "not required to keep statistics"? In today's world there is rarely no smoking gun, and it turns out in this case also. The IRS aggressively actions property liens and those are public records. The death records nationally are also public records. Therefore by combining a search for death records where the IRS has a property lien we can see such correlations.

What can we expect from such results, that the IRS does not want us to know? Alarmingly the total number of related deaths over a ten year period runs into many thousands of people. This is a unique situation; while obviously government actions and legislations result in citizen deaths, those are indirect rather than direct, (excepting law enforcement responding to situations caused by citizens actions).

In this case of persons at risk the IRS is directly responsible and from bureaucratic actions by government against citizens.

Clearly what is needed is to replace the IRS with a new means of indirect taxation that is not directly levied against citizens. One that avoids discriminating against at risk citizens. The ability to enact and implement such a system is now possible for todays modern society. The proposal is called The FAIRtax and the corresponding legislation HR 25.

Recently with have seen the Supreme Court rule on discrimination for citizens based on their birth sexual orientations and overturn hundreds of years of entrenched bureaucratic government actions.

I would urge this committee to take all steps to immediately fast track adoption of the principles and methods detailed by the FAIRtax and to take this country forward away from the dark damaging and dangerous practices that have become norm for the IRS today.

Sadly this will all come too late for two of my friends who have taken their lives as a direct result of harassment from the IRS.

American Society of Clinical Oncology

Julie Vose, MD, MBA, FASCO
President
American Society of Clinical Oncology

Statement prepared for:
House Ways and Means Committee
Subcommittee on Health

Implementation of *Medicare Access & CHIP Reauthorization Act of 2015* (MACRA)
May 11, 2016

The American Society of Clinical Oncology (ASCO) is pleased to submit this statement in connection with the hearing entitled, "Implementation of *Medicare Access & CHIP Reauthorization Act of 2015* (MACRA)." ASCO is grateful to the Ways & Means Committee, particularly to this subcommittee, for their work to develop MACRA. We provided extensive feedback to you during development of the legislation, which we publically supported and promoted.

The collaborative environment you created resulted in overwhelming bipartisan support in both the House and Senate. As a part of the provider community, we appreciate this important step toward a more rational payment system and feel ownership over this as well. ASCO will continue to work with you and CMS to ensure this legislation works for oncology providers and their Medicare patients.

The emphasis on quality and value that underpins MACRA is entirely consistent with ASCO's mission and work. For more than a decade, we have been focused on the delivery of high quality, high value care for every patient with cancer. Our longstanding performance measurement system, QOPI, is a qualified clinical data registry, which has a high degree of support and participation among our members. It is even beginning to penetrate international practices. We also are well on the path to building a rapid learning system for oncology, called CancerLinQ, which we believe will revolutionize cancer care. We are hopeful that these important systems can thrive under MACRA.

We support MACRA's emphasis on value over volume. ASCO is focused on the cost of cancer care and what it means for patients with cancer. We have developed a wide range of education and related tools that support and encourage patient-physician conversations about the cost of their care. We also have a robust portfolio of clinical guidance for physicians, including a value framework designed to inform and support shared decision-making and the selection of high value care options.

CMS Proposed Rule

CMS released a proposed rule on April 27, 2016, setting out potential regulations for implementation of two pathways for professionals to satisfy MACRA's requirements, the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). While ASCO is still reviewing the 962 page rule, a few of our initial impressions are outlined below. We look forward to sharing our written response to the proposed rule with the Committee once it is finalized.

The Merit Based Incentive Payment System (MIPS)

MACRA established MIPS as the default physician payment system to replace the SGR-based physician reimbursement system. MIPS will provide positive and negative payment adjustment to physicians based on their performance across four performance categories. The performance categories are:

- The Quality Performance Category
- The Resource Use Performance Category
- The Clinical Practice Improvement Activity Performance Category
- The Advancing Care Information Performance Category

With the exception of the Clinical Practice Improvement Activity (CPIA) performance category, the new performance categories are based heavily on existing CMS quality and value improvement programs.

Resource Utilization

ASCO has weighed-in with CMS on a number of areas in implementation of specific importance to oncology. Although we support the transition to value-based payment, we remain concerned that the MIPS methodology for measuring resource utilization could unfairly penalize an oncologist who provides medically necessary care with high-costs that are outside of the oncologist's control. Currently, CMS assesses resource use through the Value-Based Payment Modifier (VBM), which is too blunt of an instrument to protect and promote high-quality oncology care. To be successful in implementing MACRA, policymakers must learn from and avoid the mistakes made in implementing the VBM.

The treatment of cancer is clinically complex and highly specialized, creating many factors that must be considered to accurately evaluate medical oncology resource use in a way that protects the interests of patients. There are more than 120 different types of cancer (and through advances in molecular diagnostics, this list is growing), and the most appropriate treatment option for a particular patient often involves the administration of a multi-drug regimen. In many instances, the selection of the most appropriate anticancer drug for an individual patient is based on the fact that there is a single molecular entity without any clinically equivalent substitute that provides a clear clinical advantage for the individual. In these common scenarios, the medical oncologist is left with little flexibility to reduce drug utilization costs by selecting lower cost alternatives. It is counterproductive to achieving the highest quality of care for a patient to force a provider to choose one therapy over another solely due to costs that are set outside of the oncologist's office.

Congress and CMS must not assume that variations in resource needs among patients and medical oncology providers will "average out" over time. It is common for medical oncologists to specialize in treating particular types or sub-types of cancer. There are some physicians and many oncology practices that specialize in treating the most complex—and often most costly—oncology patients. In some of those instances, there will be significant differences in resource consumption compared with other providers. We are especially concerned that if resource use measurement does not account for these clinical differences, CMS may inadvertently unfairly penalize practices and create access barriers for patients with complex and molecularly unique forms of cancer. Congress and CMS should take this situation into consideration for any process used to measure resource use in oncology and should not implement such a process until there is confidence the methodology will adequately protect quality and access to care for patients with these complex illnesses.

Given the factors described above, and because drug pricing is outside of the control of treating physicians, ASCO recommends that Congress and CMS adopt a more nuanced approach for evaluating oncology resource use. We urge Congress to work with CMS to exclude the use of raw drug expenditures in resource use determinations. Instead, CMS should assess drug resource use by evaluating adherence to evidence-based, value-based medical decision-making. ASCO endorses the use of high-quality clinical pathways in oncology as a mechanism to assess the provision of such care.

Appropriately designed clinical oncology pathways are detailed, evidence-based treatment protocols for delivering quality cancer care for specific patient presentations, including type and stage of disease. Clinical oncology pathways are a tool that can be used to appropriately align incentives for cancer patients and providers for resource use assessment in

cancer care. Pathways are being used by an increasing number of private payers to ensure evidence-based, value-based care for cancer patients. Used in this way, clinical oncology pathways can enable oncologists, payers, and patients to provide assurances that patients are receiving clinically appropriate therapies without unnecessary costs, including drugs. Oncology pathways balance the considerations of clinical efficacy, safety, toxicities, cost, and scientific advances, including the growing personalization of therapy based on molecular diagnostics.[1] Simply put, clinical pathways help to ensure that the right patient gets the right drug at the right time. Since compliance with appropriately designed oncology pathways define optimal care, medically appropriate concordance with pathway programs that have been developed and peer-reviewed by oncologists should be considered a major quality indicator.

In addition to drug costs, ASCO has serious concerns that CMS is failing to implement adequate risk adjustment to assess resource use in a way that fairly addresses differences in resource use among oncologists. Cancer care is incredibly complex and growing more so with each passing year, and the costs of cancer care are highly variable depending on a patient's diagnosis, cancer stage, molecular markers, geographic access to care, comorbidities and other clinical factors. In light of these complexities, it is imperative that CMS develop a risk adjustment methodology that will be specifically used to address cancer care. Traditional administrative claims data alone are insufficient to provide a desirable risk-adjustment methodology.

We urge Congress to provide oversight in this area to ensure that medical oncologists are not subject to unfair resource use measurement due to the clinical complexity of the patient populations they serve.

Quality Reporting

Ensuring that quality reporting is based on a provider's day-to-day practice is essential for MIPS to become a useful tool for quality improvement. While we are pleased to see that CMS would use quality measures that are included in the final MIPS quality measure list *and* quality measures that are used by Qualified Clinical Data Registries (QCDRs), we are concerned with some of the uncertainty surrounding the process for approval of QCDR measures. The proposed rule would require CMS to approve QCDR measures that are non-MIPS measures on a measure-by-measure basis before providers can report QCDR measures in lieu of reporting MIPS measures. There are currently no measure sets for medical oncology or radiation oncology under the MIPS measure list. Under the proposal, we could only speculate whether

[1] Zon RT, Frame JN, Neuss MN, Page RD, Wollins DS, Stranne SK, Bosserman LD. American Society of Clinical Oncology policy statement on clinical pathways in oncology. Journal of Oncology Practice. 2016 [epub ahead of print].

CMS would exercise its oversight over QCDR measures in a restrictive or timely manner. The CMS verification process should be implemented in a way that embraces the use of QCDRs to improve patient care and should not in any way slow the continued use of existing, robust QCDR measures or slow the adoption of new QCDR measures.

We thank Congress for its continued support of QCDRs by requiring their inclusion in MIPS. For more than a decade, ASCO has offered its members the ability to participate in the Quality Oncology Practice Initiative (QOPI), which is designated as a QCDR and focuses specifically on measuring and assessing the quality of cancer care. Congress should ensure that CMS does not weaken the protections in MACRA that exempt quality measures developed for use in a QCDR from many of the measure development process requirements that other MIPS measures will be required to undergo. This exemption is of critical importance because it will give QCDRs, like QOPI, the flexibility to innovate and develop quality measures that are clinically relevant to specialty practice.

We urge Congress to work with CMS to improve quality reporting in cancer care by promoting the use of quality measures that are important to patients and have meaningful impacts on the day-to-day practice of oncology. Failure to promote clinically relevant quality reporting will continue the "check-the-box" reporting attitude of many providers toward the Physician Quality Reporting System (PQRS) used by Medicare today.

Finally, it is essential that Congress continue to support the implementation of group quality reporting in QCDRs. The promotion of group reporting is critical for oncology, since individual oncologists will rarely have enough cases, within any given cancer diagnosis, to report data that is statistically valid and representative of practice patterns and overall performance.

Clinical Practice Improvement Activities (CPIA)

The creation of the clinical practice improvement activities category offers an opportunity for CMS to encourage providers to engage in activities that can meaningfully improve the quality of care they provide. ASCO supports an attestation-based system that allows providers and groups to attest to participation in activities that meaningfully improve the quality of care they deliver to achieve the full clinical practice improvement activity score. We strongly support that the proposed rule has recognized several aspects of QCDR participation as a CPIAs; however, we urge Congress and CMS to ensure that important activities such as ASCO's QOPI Certification and provider participation in clinical trials should also be included in the proposed list.

Under the proposed rule, several of the listed CPIAs may interest oncology providers, such as participation in and use of data reported to a QCDR, participation in payment reform models sponsored by the CMS Innovation Center, and longitudinal and episodic care management.

Meaningful Use of Certified Electronic Health Records Technology

MACRA requires CMS to evaluate providers based on their meaningful use of certified EHR technology. Under the proposed rule, CMS has renamed the EHR meaningful use program: "The Advancing Care Information" and made it a performance category. Consistent with recent CMS directives, the Advancing Care Information (ACI) would move to a year-long reporting period, aligning with the other performance categories under MIPS.

Additionally, although the proposed rule would eliminate the clinical decision support and computerized provider order entry objectives from the program, the proposed rule would maintain most of the required measures and objectives in place for 2016. It would score MIPS clinicians and groups on measures and objectives that correlate to Stage 3 Meaningful Use.

For the first time, the proposed rule would allow for group reporting of ACI and would also allow for reporting through qualified registries and QCDRs. This is an important improvement over the Meaningful Use program.

We thank the House for passing *H.R. 6, the 21st Century Cures Act* which included a provision to encourage EHR interoperability. Continued efforts are needed to address the lack of widespread interoperability in the current health IT ecosystem and to alleviate administrative burdens of the meaningful use program prior to requiring full compliance with the meaningful use program to avoid adverse reimbursement consequences. Until widespread interoperability is achieved and the regulatory burdens associated with participation in the meaningful use program are lessened, Congress and CMS should not subject providers to penalties based on systemic problems that they had no role in creating.

Alternative Payment Models (APMs)

MACRA allows a second option for reimbursement through APMs. Participation in an Advanced APM would allow physicians to opt out of MIPS and receive an additional bonus over and above what is negotiated for a specific APM model.

ASCO's Alternative Payment Model

ASCO is encouraged by MACRA's strong emphasis on alternative payment models, and particularly the acceptance of those developed by physicians. ASCO has been developing and refining an APM for oncology since 2010. Our model, the Patient Centered Oncology Payment Model (PCOP), would fundamentally restructure the way oncology is paid for and better align payments with the patient services that are critical to delivering quality care.

PCOP was developed by a dedicated group of ASCO volunteers, who met once every two weeks for two years. The group included medical oncologists from diverse practice settings, seasoned practice administrators, and experts in physician payment and business analysis. ASCO used data from the National Practice Benchmark for Oncology and interviews with a sample of oncology practices to estimate the amount of time and money oncology practices are currently spending to deliver services to oncology patients—services that are not adequately supported by existing fee-for-service payments for office visits and infusions.

This model would also test many of the policy alternatives that have gained visibility recently, including bundled payments and episode based reimbursement. ASCO has estimated that PCOP would achieve savings for the Medicare program, while providing the necessary resources for oncology practices to provide high-quality, high-value cancer care. By matching payment more closely with actual care delivery, practices can organize care in a way that helps patients avoid expensive hospitalizations and unnecessary tests and treatments.

We believe that PCOP will qualify as an APM under MACRA because it meets the stated criteria in the law: includes quality measurement, requires more than nominal financial risk, requires the use of certified EHRs, and includes financial incentives. The Center for Medicare and Medicaid Innovation (CMMI) has its own model for oncology, the Oncology Care Model (OCM), which some have argued should suffice as the only oncology-specific APM. However, CMS should ensure that multiple oncology-specific APMs are available, including PCOP, to ensure that CMS explores multiple approaches to reforming oncology reimbursement. We believe that Congress intended to foster innovation and experimentation to reform Medicare reimbursement when MACRA was passed and that testing multiple approaches in oncology is preferable, given its clinical complexities.

ASCO is grateful for the pathway outlined in MACRA for physician developed APMs. CMS intends to keep the Physician Focused Payment Model Technical Advisory Committee (PTAC) process separate and independent. We are aware the PTAC is just forming, and we are hopeful it provides—as you intended—a meaningful opportunity for review and approval of high quality APMs like ASCO's PCOP, however we are concerned that there is still no assurance

the PTAC will review and recommend models to be tested as new payment models by CMS. In fact, CMS proposes to maintain CMMI's flexibility "to test models when it believes that it is the right time to do so, taking into account other models it is currently testing..." As part of demonstrating the criteria above, CMS proposes that payment models must address how it is different from current Medicare payment methodologies, and why the payment methodology cannot be tested under current payment methodologies. If this pathway does not work as intended, we hope that Congress will intervene and establish a clear pathway for implementation of APMs recommended by the PTAC.

Preparing Our Members for MACRA

In closing, we want to make the Committee aware of work ASCO is doing to prepare its membership to be ready for MACRA implementation. ASCO is using all the communications vehicles we have available to educate and inform our members about MACRA's ongoing implementation. We hope that oncologists can be among the best prepared specialists in the nation. While our hopes remain high that multiple APMs will be available for oncology, we know that many, if not most, of our US members will be in MIPS. To that end, we are encouraging participation in Meaningful Use, PQRS, and ASCO's own QCDR.

We've held full day seminars at our office in Alexandria, VA, nationwide webinars, presentations at state society meetings, and presented at ASCO's annual meeting so that all of our members have an opportunity to receive training on MACRA implementation. We have recruited a dedicated committee of ASCO's highest committee leadership to work on implementation and view it from broad perspectives. Additionally, we've conducted practice readiness assessments at individual sites to help practices understand what steps they will need to take ahead of MACRA implementation.

When appropriate, we will share APM information and help prepare our membership for all APMs available in oncology.

We know that there is much work ahead and we stand ready to work with Congress and CMS to ensure successful implementation of MACRA. We look forward to working together.

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Thank you for your leadership on passage and continued oversight to ensure successful implementation of MACRA. We look forward to continued work with you and your staff to ensure that Medicare beneficiaries have access to oncology services moving forward. Please contact Kristin McDonald at Kristin.McDonald@asco.org with any questions.

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INSTITUTE for CHILD SUCCESS

Comments for the Record of the

Hearing to Markup Bills to Improve TANF

In the Full Committee on Ways and Means

On May 11, 2016

Bryan Boroughs
General Counsel and Director of Legislative Affairs, Institute for Child Success

Introduction

The Institute for Child Success is excited by the continuing progress in Congress regarding Pay for Success financing models (sometimes called Social Impact Bonds) that can advance the well being of young children and their families. We thank Chairman Brady for holding this hearing, Representatives Young and Delaney for their leadership on H.R. 5170, and also the many members of the committee who have joined in co-sponsorship. We were also excited to see that the provisions encompassed a range of outcomes, especially including education and health outcomes, that are sometimes overlooked when working to advance the self-sufficiency of needy families. Indeed, failing to meet a basic threshold for those outcomes will often preclude improved workforce outcomes for families.

The Institute for Child Success respectfully submits the following written comments to the hearing record for your consideration. In these comments, we begin with an overview of our perspective on the benefits of Pay for Success financing. We then discuss the substantial benefits of federal involvement, the reasons that legislation is necessary for meaningful federal engagement, and the ways in which this legislation responds to that need. Finally, we address some specific questions and concerns that were raised during the hearing, regarding how Pay for Success works both in practice and as defined in H.R. 5170.

Though H.R. 5170 deals with a broader array of Pay for Success or Pay for Performance tools, and the Institute for Child Success is generally supportive of those tools, we limit our comments here to the model that is sometimes called "Social Impact Bonds" or Pay for Success Financing.

Benefits of Pay for Success Financing (or, Social Impact Bonds)

Pay for Success financing is a model that can help effective interventions scale up to improve outcomes for young children and their families, while reducing or eliminating financial risks to the taxpayers. The fundamental structure is well known to many, so we will only provide a very brief overview here. That most basic theoretical structure involves four pieces:

- An intervention that has been tested, and has demonstrated that it reliably produces outcomes;
- Investors who provide the upfront capital required to bring the intervention up to a larger scale;
- A government entity that is interested in paying for those outcomes – sometimes using funds saved as a result of those outcomes – if the agreed-upon success measures are achieved; and
- An independent evaluator that determines whether the intervention accomplishes the pre-determined measures of success and, therefore, the government should repay the investor.

Because of the relative novelty and complexity of these projects, a third-party intermediary has also been involved in many of the Pay for Success contracts entered into to-date.

Pay for Success financing provides a number of benefits over traditional government mechanisms for selecting and scaling up interventions, including:

- It allows governments to shift resources towards effective prevention and early intervention;
- It draws on expertise and energy from outside investors, who bear much or all of the financial risk if a program is ultimately not as effective as expected;
- A rigorous cost and benefit analysis is necessary to even consider a Pay for Success arrangement, increasing the ability of the government to invest wisely;
- Outcome tracking is a centerpiece at every step, allowing the necessary tracking processes to be "baked in" to an intervention from the very beginning; and
- While Pay for Success *does not* privatize critical government services (such as remedial education, criminal justice, or the like), it *does* hold the potential to reduce the overloaded demand on many of those services, allowing them to better fulfill their missions.

Pay for Success and Effective Early Childhood Interventions

As we discussed in our 2014 brief on this topic, Pay for Success is particularly well suited to help scale effective early childhood interventions.[1] Many interventions exist today with long-term outcomes that are independently compelling, create significant value for governmental entities, and produce outcomes that advance TANF's goal of improving family self-sufficiency and improving workforce engagement. Those outcomes include:

- More economically independent mothers,
- Reduced incarceration rates,
- Fewer teen pregnancies,
- Fewer closely spaced second births and fewer preterm second births,
- Fewer injury-related visits to the emergency room,
- Reductions in child maltreatment,
- Less youth crime,
- Higher achievement in school or careers, and
- Increased lifetime earnings.

Yet despite wide agreement that we should develop and implement these effective early childhood interventions broadly, it is very challenging to do so. Many governmental agencies are working to

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[1] Institute for Child Success. *Pay for Success Financing for Early Childhood Programs: A Path Forward*. 2014. Available at: http://www.instituteforchildsuccess.org/mydocuments/pay_for_success_financing_for_early_childhood_program2.pdf.

implement effective early childhood interventions, but those efforts are far from full-scale. Two barriers stand out:

1) **Resources are tied up in responding to problems, leaving little room for prevention.** Governments are busy putting out fires – that is, responding to problems after they happen – and after more cost-effective responses are no longer an option. Given the fiscal and political pressure faced by all governmental entities, government is rarely able to devote sufficient up-front resources to developing or implementing effective methods to prevent problems in the first place, even if those approaches would save money in the long run. For instance, the Institute of Medicine has documented the costs of failing to focus on prevention, finding that many mental, emotional, and behavioral disorders in young people are preventable, but that prevention remains underfunded.[2]
2) **The costs of wide-scale implementation are immediate, but the payback takes time.** Although many programs will deliver both social and financial returns, those benefits take time. Governments often find it difficult to afford investments with delayed returns.

Pay for Success can help address both of those barriers. Governments are able to implement tested interventions without immediately burdening the budget, since the model allows governments to wait until the relevant outcomes are met before payments must be made. If those interventions are ultimately effective at scale, then any resulting cost-savings can be used to help repay the investors' principal and any premium that is agreed to at the outset. Moreover, if the interventions do not produce the agreed-upon outcomes, then the government does not have to pay.

Why Does the Federal Government Need to Get Involved

One of the questions that often arises in discussions about Pay for Success is this: Why is it important for the federal government to get involved? The simple answer is that many effective interventions produce positive results and save money at both the federal and state or local levels, and - for many of those - the federal government has a significant interest. For example, some two-generation early childhood interventions result in the improved birth spacing and more economically self-sufficient mothers, and therefore reduce dependency on programs like TANF. Congress should, therefore, position federal programs to foster and leverage those outcomes. If it does so as structured in H.R. 5170, both states and the federal government will benefit.

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[2] National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. 2009. Available at http://www.ncbi.nlm.nih.gov/books/NBK32775/

In addition, the federal attention and support for outcome-based payments will incentivize jurisdictions around the country to increase accountability for outcomes in government programs. Identifying the most effective programs and tracking their outcomes requires capacity and effort. This legislation will support and incentivize jurisdictions to build that capacity. The result will be more cost-effective government investments and better outcomes for our communities and our country.

Why Do We Need Legislative Action to Support Pay for Success

The typical appropriations process presents two significant barriers that prevent agencies from engaging in meaningful Pay for Success deals, both of which are addressed by H.R. 5170. First, federal appropriations typically have to be "obligated" by September 30 of any given fiscal year. What we've learned over the last few years is that many of these deals take more than one year to develop to the contract-signing phase. Knowing that the money may evaporate after months of diligent work, but before a deal is finalized, is a substantial hurdle.

Second, federally appropriated dollars typically have to be disbursed within 5-years after the fiscal year in which they are appropriated (under 31 U.S.C 1552(a)). Many Pay for Success contracts are best suited to something a little longer than a 5-year window, if only because most programs take a couple of years to reach scale, and long-term outcomes may take several years to be fully measured after that. As an example, the first Social Impact bond out of the United Kingdom was a 6-year contract.

Both of those barriers require Congressional action, but the fix is relatively simple and is handled in H.R 5170. However, there is a larger challenge the federal government will face as it engages in Pay for Success financing projects, and that is a challenge of human capital. Federal entities are generally not experienced in this field, and we need to develop that expertise in a deliberate fashion. Through the commission created in H.R. 5170, we can begin building expertise throughout the federal systems, allowing us to operate more efficiently in this field going forward.

What are the Limitations and Challenges of Pay for Success Financing

As with any exciting new model, it is easy to lose sight of the limitations and challenges. There are some problems for which Pay for Success is simply not a solution. For example, it does not provide a sound model for providing ongoing funding programs, or for encouraging better evaluation of programs, that are already operating at scale.[3] It also is not yet well-suited to fund untested innovations (though, a robust Pay for Success mechanism might encourage novel innovations to look to earlier evaluations).

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[3] Some Pay for Performance systems, which are supported also by H.R. 5170 but are beyond the scope of these comments, would allow for ongoing funding and evaluations.

Similarly, Pay for Success might not make the most sense for those specific services in those rare circumstances where success is nearly guaranteed, because the model does involve premium payments in exchange for investors bearing the risk of failure. In a case where there is virtually no risk, then the investment would be less beneficial from a financial perspective. Even in that scenario, however, Pay for Success financing may provide governments with the fiscal relief they need to help shift resources from remediation towards prevention by enabling them to pay at the end of the project rather than at the beginning.

Moreover, Pay for Success financing deals are difficult to put together, from a technical perspective, so they are currently only appropriate for larger projects where the benefits exceed the transaction costs.

What are some of the technical challenges of Pay for Success financing?

- **Identifying rigorously tested interventions:** We have to find and develop interventions with rigorous evidence of outcomes. There are many interesting interventions out there with great confidence in, but little proof of, their results. So the first hurdle is identifying the rigorously tested programs, and then also encouraging promising programs to develop the kind of evidence that investors and governments need. H.R. 5170 draft wisely emphasizes the importance of feasibility studies to address both of these issues.

- **Identifying governmental entities:** One difficulty here flows from the fact that many governments are interested in this model primarily for interventions that produce net cost savings (in that they cost less now than they save later). However, those savings may spread among various governmental entities, especially with early childhood interventions, from Medicaid to juvenile justice to education. It is sometimes difficult to find a single agency that reaps enough of the benefits, then, to afford the full costs of a successful program. H.R. 5170 addresses this issue in two ways. First, it provides for a single entity that can look at benefits across the federal government and, second, the legislation is created to support state and municipal deals that impact federal priorities.

- **Identifying appropriate outcome metrics:** We have to be very cautious to identify outcome metrics with which the service providers, the investors, and the government are all comfortable. This is one of the most challenging elements, particularly with respect to concerns over creating perverse incentives. PFS financing should avoid the danger that providers will "game the system" by determining outcomes compared to a control group or a matched comparison group. If the evaluation is well designed, any changes in how outcomes are counted will affect both the program group and the control group and thus will not translate into better results. This challenge is also why building expertise and collaboration within the federal contracting system – as H.R. 5170 envisions – is critical to long-term success.

- **Building the system to measure success:** As mentioned above, a centerpiece of Pay for Success financing is rigorous and ongoing outcome measurement, which is challenging for even the best-resourced programs. Pay for Success, however, builds that evaluation into the model from beginning to end, and in such a way that it cannot get lost in the shuffle – investors only invest, and only get a return, if successes are measured and verified by an independent evaluator. H.R. 5170 supports that model by expressly requiring that the evaluation mechanisms be identified at the beginning.

Given these difficulties, why is so much progress happening anyway?

- **Investors are asking for it:** We frequently hear from bank executives that their high-net-worth clients increasingly seek investments that are aligned with their values. More and more, the industry is focusing on generating both direct financial returns *and* positive social outcomes.

- **Governments are looking for more cost-effective strategies to achieve public goals:** Governments – at all levels, but including the Federal Government through TANF and other programs – spend a tremendous amount of resources responding to crisis situations and providing remediation services. Those governments would normally have to sacrifice some of those critical services to invest resources in early interventions. Pay for Success allows governments breathing room to pay for interventions, in full or part, out of the long-term savings they produce. Moreover, Pay for Success financing helps governments move in a direction they are increasingly interested in: toward analyzing benefits and costs of specific strategies and choosing the ones that produce the best value for taxpayers.

Specific Questions and Concerns Raised During the May 11, 2016 Markup

We were encouraged to hear members of the Committee asking exactly the type of questions we should be thinking through during the May 11 hearing. Committee staff provided helpful answers with regard to the specific provisions of the bill, and we would like to add additional context here from the history of the Pay for Success field.

Many of those questions asked what guiderails or other protections are included in H.R. 5170 against potentially problematic provisions in a contract. Fundamentally, the first round of protections occurs before a proposal is submitted to the Commission envisioned by H.R. 5170. That proposal has to describe a range of decisions with which local governments, local service providers, and local investors have agreed. Each of those entities have to be comfortable with: the definition of what success looks like; who will independently evaluate that success; the costs associated with the project, the potential return for the investors; and – of course – who each of the parties to the agreement will be. The federal government's role, as envisioned in 5170, is predominantly then determining the value to the federal government from the deal and – based on that valuation – which projects (if any) are the best investments for the federal government to support.

We go into more specifics below based on the history of PFS transactions in the US. More detail on those transactions can also be found using some publicly available resources. ICS has produced a summary matrix of the first nine US deals, which includes information about investors, evaluators, intermediaries, providers, and the jurisdictions involved. That summary is available online at http://bit.ly/PFSSummariesApril2016. Two subsequent projects have also been announced in South Carolina (fact sheet here: http://bit.ly/PFSSouthCarolinaDHHSApril2016) and Connecticut (press release available here: http://bit.ly/PFSConnecticutPressReleaseFeb2016).

Speaking to specific questions and concerns discussed during the hearing:

- **Who are the evaluators associated with these projects?** Prior evaluators have included: the Burnes Institute for Poverty and Homelessness; the Center on Urban Poverty and Community Development at Case Western Reserve University; the Evaluation Center at the University of Colorado Denver; J-Pal North America at the Massachusetts Institute of Technology; MDRC; New York State Departments of Labor Research and of Correction and Community Supervision Research; Root Cause Institute, Inc.; Sibalytics LLC; SRI International; University of California San Francisco School of Medicine; the Urban Institute; Utah State University's Early Intervention Research Institute.

- **Who selects the evaluator that ultimately determines if a project is successful? Does the investor have a say in the selection process?** This decision is part of the overall contract negotiation process. Investors would typically have to agree to the selection of an intermediary prior to entering into a contract, as would any jurisdictions or service providers who are parties to the contract.

- **Who are the investors associated with these projects?** Prior investors have included a range of philanthropic organizations, non-profit organizations, private investors, and banks, including: Adobe Services, Inc.; Bank of America Merrill Lynch; the Ben and Lucy Ana Fund at the Walton Foundation; Living Cities; Blended Catalyst Fund; Bloomberg Philanthropies; the BlueCross BlueShield foundation of South Carolina; the Boeing Company; the Boston Foundation; the California Endowment; the Cleveland Foundation; the Colorado Health Foundation; the Corporation for Supportive Housing; the Denver Foundation; the Duke Endowment; Finnegan Family Foundation; the George Gund Foundation; Goldman Sachs; Google.org the Health Trust; Greenville County, SC First Steps; J.B. and M.K. Pritzker Family Foundation; the James Irvine Foundation; the Kresge Foundation; Laura and John Arnold Foundation; Living Cities; New Profit Inc.; Nonprofit Finance Fund; Northern Trust; the Piton Foundation; the Reinvestment Fund; Roca Inc.; Robin Hood Foundation; Rockefeller Foundation; Santander Bank; Sisters of Charity Foundation of Cleveland; the Sobrato Family Foundation; Third Sector Capital Partners, Inc.; the United Way.

- **Are there limits to the return investors can get? Who determines the rate of return?** The rate of return at various levels of success is part of the overall contract negotiation process. All parties would typically have to agree to the repayment terms prior to entering into a contract. To protect against potential windfall returns, in the event that a project succeeds beyond expectations, contracts can include a cap on the total returns. This was the case in Utah's pre-k project, which included a cap at 5 percent above the municipal bond rate. Local parties in future transactions can similarly tailor the risk and return profiles to best suit the local needs.

- **Can investors terminate their efforts in these projects early? Do the contracts have parameters regarding grounds for investors terminating their effort in a project?** Contingency plans for winding down a project early are typically also included in the contract negotiation process, and those plans would be agreed to by all parties as part of that process. For instance, the project at Rikers Island included two interim evaluations; if the project was not performing as expected, the investor could wind down the project. Approximately 2 years into that 4-year project, the first interim evaluation showed that the intervention was not producing the desired outcomes, and the project ended.

- **Who are the intermediaries associated with these projects?** Not all projects have included an intermediary, though most have. Prior intermediaries and/or borrowers have included: the Corporation for Supportive Housing; Enterprise Community Partners; IFF; Massachusetts Alliance for Supportive Housing; Social Finance US; Third Sector Capital Partners; the United Way of Massachusetts Bay and Merrimack Valley; the United Way of Salt Lake; and Vera institute of Justice.

- **Who determines 'success' or outcomes in a Pay for Success project? Do investors determine success?** The definition of success is the core feature of the contract negotiation process; the definition must be something for which a jurisdiction is willing to pay, service providers are willing to be held accountable, and investors are willing to accept the risk. Each party is critical in shaping the picture of success and how it will be measured.

- **At what point(s) do these projects determine they have achieved 'success'?** The timeline for determining success and outcome payments is also detailed during the contract negotiation process. Timeline is determined based on the time needed to achieve the outcomes of interest as well as the appetite of investors for short- or long-term investment. Prior project have been scheduled to last for: 4, 5, 5.5, 6, 7, 12, and 17 years.

- **How are the players in a project chosen? At what point in the process are the investors engaged?** The choice of parties is very closely related to the definition of success, level of acceptable risk, and the rates of return. As such, investors are often engaged relatively early in

a deal structuring process. However, the exact timeline of the engagement of potential investors varies widely and has sometimes occurred after months of preliminary negotiations between jurisdictions and service providers.

- **If a feasibility study was an early element of the project, what was the timeline associated with its development?** The time and cost associated with a feasibility study varies widely based on project needs, and only some are published or publicized. We have seen several studies that take between several months and a year.

Conclusion

Pay for Success Financing is a promising tool for improving social outcomes and government efficiency. The Institute for Child Success is encouraged by the attention this financing model has received by our elected officials at the federal level, and we are even more encouraged by the Committee's positive vote on H.R. 5170. This financing model is challenging, especially for the federal government, but has tremendous potential for improving our collective fiscal position while directly improving social outcomes. We look forward to continued work with the Committee and Congress on this issue in the weeks and months to come. Thank you for the consideration of these comments.

About the Institute for Child Success

Headquartered in Greenville, South Carolina, the Institute for Child Success (ICS) is an independent, nonpartisan, nonprofit research and policy organization dedicated to the success of all young children. ICS pursues its mission in four primary ways: proposing smart public polices, grounded in research; advising governments, nonprofits, foundations, and other stakeholders on strategies to improve outcomes; Sharing knowledge, convening stakeholders, embracing solutions, and accelerating impact; and fostering the next generation of leaders. For more information, please visit: www.instituteforchildsuccess.org.

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