

THE BROOKINGS INSTITUTION

CAN MIPS BE SALVAGED?

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PARTICIPANTS:

Welcome and Overview:

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Panel 1: How is MIPS Working?

Moderator:

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Panelists:

SHARI ERICKSON
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TIM GRONNIGER
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Panel 2: Should MIPS Be Reformed?

Moderator:

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Panelists:

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House Ways & Means Committee

JIM MATHEWS
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MedPAC

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P R O C E E D I N G S

MR. GINSBURG: Yeah, I would like to welcome you to our conference this morning, which is devoted to the Merit Based Incentive Payment System - a word probably a very few of you could recite, also known as MIPS. And MIPS was part of the Medicare Access and CHIP Reauthorization Act of 2015 or MACRA.

And to both physicians and to many in Congress, first thoughts about MACRA are they ended the sustainable growth rate or SGR - a policy enacted in 1997 which -- that spun out of control a few years later and occupied Congress for over ten years with short-term fixes to finally get a handle on it. But MACRA not only ended SGR but it also put in place reforms in physician payment for the Medicare Program.

Most attention has been to the bonus for physicians participating in advanced alternative payment models. And as I say most attention, it's not so much the number of physicians getting a five percent bonus but that here is Congress speaking, pointing the way to how it wanted the Medicare Program to evolve. And this was a very broad consensus in Congress and, I think, very much applauded throughout the healthcare system.

But MACRA also included MIPS which applies to physicians not participating in advanced alternative payment models. It streamlined some existing pay-for-performance programs in Medicare. Now MIPS has had what you might call a rocky start. CMS delayed parts of it and exempted very large numbers of physicians in smaller practices. Physicians raised concerns about the burden and the cost required to do the reporting required in MIPS and policy analysts examined the track record, the ledgers, and raised concerns about their relationship to the quality and cost goals and whether they reliably identified good and bad performers.

In January, MedPAC voted to recommend to Congress that MIPS be eliminated and that a new voluntary value program be established that would measure the performance of groups that physicians would form on a voluntary basis. This

conference is organized to discuss the recent experience with MIPS and ideas to address its shortcomings. Our initial announcement listed Joe Grogan as the opening speaker. He had to drop out because of his scheduling issue. So, decides just to proceed with our two panels.

The first panel is going to discuss how MIPS is working. It's going to focus on the experience of different types of physician practices with MIPS. And the second panel will discuss ways to reform MIPS. The first panel will be moderated by Kavita Patel, who practices medicine at Johns Hopkins Medicine and contributes to our work at the USC-Brookings Schaeffer Initiative for Health Policy as a nonresident fellow at Brookings.

MS. PATEL: All right. Thank you, Paul and I am going to go ahead and I am going to briefly introduce our panel. Each panelist does have slides and as a result I couldn't help but put in -- I was able to get some slides myself. But, as Paul mentioned, and I know there are a lot of you watching on the webcast, we are going to talk about how MIPS is actually working on the ground, but we can't help but offer a potential foray into some solutions or at least trying to bridge to our second panel, which Paul will be leading.

So, starting to my right, we have Valinda Rutledge, and they are in the order of appearance as well, the vice president of public payor health strategy from the Care Coordination Institute of the Greenville Health System in South Carolina. Shari Erickson, the vice president of governmental affairs and medical practice at the American College of Physicians. Aaron Lyss, the director of strategy and business development at Tennessee Oncology. And Tim Gronniger, senior vice president of development and strategy at Caravan Health.

All of these people have much longer bios associated but in the interest of getting us to what we want to do, they can each talk about, kind of, their respective roles during their presentations. I decided to put in a couple of very pragmatic slides

around -- oh, here we go, let's see. I just have to pull up the PowerPoint myself. Okay. That sounds like I am in a little -- all right. So -- all right, every single one of you have to pull up the PowerPoint and then somebody is going to make it sync with the screen.

So, what I decided to do while we are waiting for it to come up -- I mean, it's on full-screen. It's not my full-screen. Oh, everybody has to do this? Okay. All right. I was a chief resident. I am ready for all the -- okay. So, here we go.

So, I wanted to just do this a ground refresher because I think that everybody on both of these panels are extreme experts for the MIPS program but just wanted to, kind of, offer a little bit of like level-setting for the categories. And, by the way, last week the administration released the proposed rule around the physician fee schedule and the QPP program and a number of other changes. So, there is actually some tweaks and adjustments to even what you see here.

But needless to say, as Paul mentioned, this was all an attempt to make something better than what was previously there in various programs and some of us might talk about this. I wanted to just bring up -- I practice, a plurality of my time, in an employed community-based, non-academic community-based primary care setting that is on fee-for-service -- 98 percent of our revenue is fee-for-service. 40 percent of my practice across eight primary care physicians and four specialists is actually Medicare. So, there were many of us but we all roll up into one big tax ID number across many sites.

So, because of our performance and volume and thresholds, we actually are all contributing to MIPS. I did look up my MPI quickly to see if I could be out of MIPS. That was the first thing I did and unfortunately, I wasn't. So, I just want to -- I am going to briefly show a couple of our -- couple of how we do things internally. We run EPIC. I have just been interacting with our IT team over the last several days to understand what workflows are, what our investments have been. I have asked to quantify what our financial investment has been to just stand up the MIPS requirements.

And basically, I was told that they were too large or too scattered to really congregate and put into one-dollar amount. But needless to say, it's a lot less than what our bonus that we received -- was, which was approximately two percent, kind of, MIPS adjustment. And it's not even fair to call it a bonus. It's really just, kind of, meeting some of these performance goals.

I just decided to take some of things that I had to do at the staff level and then what we have to do to coordinate the builds in our electronic health record. And because of changes in requirements we are going to have to just keep doing these continuous changes in builds. Not going to read the slides to you. I think the more interesting thing -- and I am not expecting you to read. This is my personal dashboard. And you will see that I have a lot of reds in areas which, you know, tell you what probably a practical practicing physician experiences. There are some things that have denominators that don't apply because they are not relevant to my population but because of our need to build across an entire system, they are put on to our dashboard

I bring up the granularity of my personal dashboard, one, to drive home the point that as practicing physician, I actually don't ever use this dashboard. It's completely meaningless to me, especially since there are so many things that don't apply to me personally, yet this is considered customized for myself.

And then at the same time, I think one of the greatest opportunities -- and Tim Gronniger and others at Brookings and I have discussed this, is that I don't really know quite what to do to improve in areas where I do have, kind of, red and I need to go into green, like closing referral loops for specialist reports which I feel like is part-electronic that much of our work -- specially at like place like Johns Hopkins where we get lot of referrals and then send out a lot of referrals back, is done over fax.

So, there are things that are just very, kind of, complicated. I don't want to go through each of these steps. But did want to show you what a very practical, on a daily basis, kind of, what our view as a practicing physician might look like. And then I do

have the ability to do a lot of things inside of my health record to, kind of, look at patients and look at things. Quite honestly, I don't have the time nor do I have the motivation to do it.

And I asked, just to, kind of, put a little finer point on this, some of the recent changes around the MIPS program that have been proposed last week, which I think, in general, are positive changes. My question to our system leadership was what are we going -- what do we sacrifice? What are we not going to do because we need to do some of this activity around getting the dashboards up, getting the workflows right.

Something as simple as measuring blood pressure alone and reporting on that quality metric can take approximately, you know, 200 hours of, kind of, time on the electronic side and then on a physician workflow side can take even five to six times that.

So, we have spent almost a thousand hours like in aggregate across our practice and across different personnel to really understand how do we implement measuring and then controlling hypertension. So, I bring that up because at the same time we are also trying to be -- we are a level one accountable care organization and the truth is that a lot of the activities we are doing in MIPS, frankly, are coming at a cost of our ability to advance in other, I would say, 'risk-taking population health based models' because it is a fixed-sum game. There is only so much time that I can ask of fellow doctors and medical assistants and front desk schedulers and then there is only so many resources we have primarily on our IT side to actually help us do some of this.

So, with that I just offered a little bit of a pragmatic view from my perspective, but I think a lot of my colleagues would echo this and, kind of, say the same things. So, I will hand it over to Valinda. We are going to go through -- each speaker is going to have, kind of, our presentation, then we will have a Q&A period afterwards.

Thank you.

MS. RUTLEDGE: Thank you, Kavita. Thank you, Abby. I don't know if I

could figure out how to pull up the slides.

I am Valinda Rutledge. I am the VP of public payor strategy at Greenville Health System. Thank you. There we go. Yes, great.

Greenville Health System is a part of a new health company. We recently merged with Palmetto Health. So, GHS and Palmetto Health has come together. As you can see we are one of the largest systems in South Carolina. We have a total of close to 2,800 physicians in our CIN and about half of them are employed and half of them are independent physicians. So, that's pretty unique. A lot of CINs either have a predominate of employed physicians or maybe much smaller with a large amount of independent physicians.

What also makes this unique is because South Carolina is little bit different than the north-east. We have a large amount of rural areas. So, we have 32 percent of our practices that's in our CIN is in -- you would classify as small practices, in rural areas.

So, the ongoing role challenge that we have had in MIPS is that the IMM EMR vendors require significant upgrade of fees and rate increases in order to have upgrades in the product to be able to report MIPS requirement. So, not only do you have the initial investment that you have in putting the EMR in, that you also have yearly upgrade fees that are pretty substantial for our rural providers.

Second, in a quality outcome measures, the absence of a risk adjustment is not addressing the older and sicker populations that you currently see in the rural area. As you know, currently in MIPS smaller practices have -- you can get a small practice bonus but that still does not level the playing field in the competition between the rural and urban practices that you will see. Also, there are a very few alternative payment models that urban providers can actually participate in.

The fourth issue is a lack of connectivity that many rural providers have with other rural providers. Many of the SNFs that are in rural areas lack any type of EMR. So,

that makes it very difficult of rural providers to connect with other rural providers in their area to be able to have effective integration activities.

Also, rural providers have been running lean for decades and they simply don't have enough staff to be able to address all the MIPS complexity. Many of them, as you know, may have one or two providers in the office, may have one mid-level provider in a part-time office staff. So, that's very lean operation that makes very difficult for them.

And final, the MIPS implementation cost far exceed the potential for positive adjustments. The number of billings that they have, the ones that do not qualify for exemption -- the number of billings that they have are very very small and yet the cost of the implementation in terms of implementing MIPS requirement far exceeds that.

So, I am going to share with you a tale of two cities. So, the first tale is our MIPS negative ROI. So, once upon a time, we had a very large and sophisticated clinically integrated network that had 30 to 35 percent rural providers, which means that they need an extra amount of time to be able to comply for MIPS. We recognize that we had to spend a lot of time in terms of helping our partners be able to comply with MIPS and able to deliver a high-quality care in the areas that we serve.

So, we spent a lot of energy in terms of giving them extra resources. We hired staff, we spent side-by-side with their practices. We would actually go into their practice and sit down with all members of their teams. We hired dozens of additional full-time staff that we calculated we worked tens of thousands of hours to provide the education, the support, and the information technology resources that was needed to meet the MIPS requirement.

And we did so well that we ended up close to 95 percent when we got our MIPS score back which made everyone -- the 2,400 physicians -- very happy until we realized that that 95 percent gave us 1.59 percent payment bonus. And that included the exceptional performance bonus in that. We calculated out what that was compared to the cost that we used and it came out to 60 percent. So, for every dollar we spent in complying

with MIPS, we only got 60 cents back on it. And as you can imagine, that's not a sustainable system going forward.

So, the second tale is then we had to really look ourselves in the mirror and say so, what should be our next step. Do we stay in MIPS in which we can hope that we can do better than 60 cents on the dollar and/or do we need to take a look at it from another perspective? And so, the perspective we chose to begin to look at it is that MIPS is -- has to be a stepping stone in terms of looking at the competencies to move into advanced alternative payment model. Without being able to get that five percent bonus in advanced alternative payment model, there is no way we can continue to survive in terms of getting 60 cents on every dollar that we put in terms of just complying with MIPS. Thank you.

MS. PATEL: Thank you, Valinda. We will have time for questions. I am smarter now. I am going to help Shari get the slides up while she comes up here. Right. Since I saw how to do it, I thought it would just be easier. Okay, here you go.

MS. ERIKSON: Excellent. Thanks. So, I am Shari Erikson. I am vice president of governmental affairs and medical practice at the American College of Physicians. And we represent 153,000 internal medicine physicians across the country and some internationally as well. Our membership is made up of about half primary care general internal medicine specialists as well as sub-specialists in all different types of internal medicine, oncology, rheumatology, homonology, lots of ologies.

And so, we do have, kind of, a unique view on this because of the makeup of our membership. And even within the membership, our members are in academic centers, they are in track, you know, to ACOs, they are in pioneer ACOs, they are in small practices. I would say though that probably most of our members -- a large significant number of our members are in the MIPS program. And that was expected just as it was across all of the eligible clinicians that were participating in MIPS.

So, I hear a lot about it from our members and wanted to reflect on some of the things that I have been hearing from our members and, sort of, give you some

buckets of what those look like from their perspective and their experience within MIPS. Let's see -- I got it.

So, I kind of grouped it into a few different areas. And measures is a biggie. So, and this has come up. But I would say what I hear about most from our members is the fact that they really don't trust, they don't believe that these measures that they are reporting on are ones that are meaningful to them, their practice, and their patients. And I think that there is a lot underlying that. And that's not unique to MIPS necessarily or, you know, really to -- it cuts across, I guess, all of value-based payment programs.

But it's something that I think we need to start to address and I will talk a little bit more about that as well. There are too many and yet too few measures. So, you know, when our Performance Measurement Committee looked at the measures that are included in the MIPS program, I think, they found about a third of them are viewed as clinically valid that should be, you know, used by clinicians in the field.

Yet, when you look at it more broadly than that there are measure that are, sort of, in those other sets that are, quite frankly, maybe more meaningful to patients or to other stakeholder groups that are also involved in this process. So, we need to be very thoughtful about how we look at those measures that are included in the program. And yet, also there are too few. Some of our sub-specialists really do struggle with having enough good measures that they feel are meaningful enough to use when they are reporting for the program or any value-based program.

And then there are multiple alignment efforts. And I mentioned the work of our Performance Measurement Committee, there is also working within in QF to endorse the measures. There is the work of the MAP which provides the pre -- you know, sub-regulatory, pre-regulatory guidance to CMS. There is the work of the Core Measures Collaborative that has identified sets of core measures and is going to be getting up and running again soon along those lines.

So, and each of those movements, so to speak, or entities have had different approaches for actually very different, very good reasons because of the different stakeholders perhaps that are at the table and the different types of goals that they have set for themselves. And so, we need to think about that and I will talk more about that in a moment too.

Another big bucket is the Health IT overall. You know, our members are very frustrated with the Health IT, with the EHRs that they use daily. The usability of those is an extreme challenge and particularly when you get it, when you tie it into the need for reporting. Add layers in additional what they feel are -- are very unnecessary additional clicks, additional data entry, re-entry of information, and the readiness of vendors which is a real challenge.

So, the vendors, I think this came up earlier when Kavita was talking, have to upgrade and then the practices need to pay for that and be sure that they -- that it's there in time for them with a full-year of reporting required for quality and proposed again to be required for quality. That's a real challenge if the Health IT is not up to speed and ready to do that.

And 'meaningful' interoperability. And I put meaningful in quotes because meaningful is used all over the place in this town. So, but what I mean by that is that, you know, we do need to share all the data, right? We do need to have those flows in place and we don't want blockage of that data. But, you know, when you -- when physicians really are taking care of a patient, they have someone in front of them. They don't need every piece of data about that patient in front of them. They need what they need to be able to pull at that time to help that patient in that episode of care. And that is where we need to try to get to and that is not where, I think, that we have gotten to yet and it needs to be a place where we start to think very thoughtfully about what we mean by interoperability.

There is a lack of clinician engagement and understanding. And when I

think of engagement, I think of so if you are in a larger institution, you have some leaders who are maybe physicians or clinicians in a C-suite or somewhere thinking about what -- looking at all the data they have available and what are the real measures and what's the smart way to go about this. How can we do the best we can do in this program. But then you have the frontline clinicians thinking, well, they told me I have to report on this, I don't know why. I don't know -- it doesn't mean anything to me necessarily in this clinical encounter that I am in or in the, you know, 20 of them that I did today.

So, we need to figure out how to engage those clinicians in this decision making as well. And then when you get into smaller practices, less integrated systems, there is a real lack of understanding and ability to make that -- to make those decisions with the same level of data and then much less know how to report it because there are lots of different options and different timing around it.

And then clinician accountability in what is a very fragmented system. Patients, you know, maybe very tied into their primary care clinician in terms of all of their chronic care that -- for their multiple chronic conditions, yet they may have a need or a want for very valid reasons to see a different clinician, a different provider in another setting because of, you know, maybe they are travelling, who knows. You know, maybe they are just sick in the middle of the night and may need to go somewhere.

And yet, there is no really good way for that information that gets interoperability again to necessarily get back that primary care clinician on a consistent way for them to be able to then be accountable -- then they are still accountable for the patient themselves. And that happens across organizations and within organizations as well. The complexity of the program, I have hinted at that. It really doesn't need to be as complex as it is. There are certainly some parameters within the law that are required to be met but -- and then the scoring also doesn't need to be as complex as it is.

The annual changes -- this, I think, came up and will come up some more. You not only lead to a lot of additional cost, they lead to a lot of additional

confusion and lack of an ability for an organization large, small or in between to plan ahead. And MIPS still does require, sort of, your feet in both boats. It requires you to be fully invested in fee-for-service. You still have to document every code, you still have to do all of that work while by the way trying to, sort of, inch your way into what's called value-based payment. And it's not easy to transition there.

So, is there still value? So, I have laid out all these challenges that I hear about on a regular basis from our members. And I would argue there is still some value in the program. The intent of the program was really to streamline to tie together some existing very disparate programs that were out there.

And if you look at what's going on, I mean, ACP does -- quality improvement programs across the country. And I will tell you those things work. When you implement those and implement them well and they may actually mean that the physician or clinicians or the staff have to do some extra steps, document maybe some extra stuff even for those -- for the quality improvement work. But they don't generally mind that because it actually -- they actually are engaged, they actually see that it's meaningful to themselves, to the patients, to the outcomes of those patients.

So, how can we figure out how to translate what we are learning there into the MIPS program? And alignment and improvement of measures, I don't think it's out of reach. But it's going to take real courage wrapped in compromise. All of us are going to have to think about that.

I mean, we still need to fly this plane but how can we actually make some changes to those measures? How can we actually get rid of the ones that are really not good measures but also address the issues that many sub-specialists or specialists are facing with not having enough and get to a place where the measures are trusted because there are some -- there are some that are trusted and viewed as valuable by clinicians. How can we get a place where we use as many of those as we can while also getting to the measures that are more consistent and useful and helpful to

the patient?

And so, I think, we just have to really think through how to do this and be a little bit courageous about it. I think MIPS can actually be simplified and streamlined. I think that there are more -- and I can talk all day about that but I want to also get to our other panelists. There are more pathways and more on-ramps that, I think, could be put in place to get to APMs freeing up some of that work that's being done to rebuild to do that, so that Kavita's organization could actually invest in population health instead of having to rebuild based on the tweaks and MIPS.

And then practices and systems can and many actually do take very thoughtful approaches to their decision making around the measures that they are using and the approaches that they are taking, and we need to learn from them. They are not all looking just at the bottom line. Some of them really are engaging the clinicians on the ground and making very thoughtful decisions based on what they have available to do this work. So, how can we learn from that and how can we actually reward those individuals and groups.

MS. PATEL: Thank you, Shari. All right, Aaron, go ahead and come up here, we are getting -- got a workflow till I get the slides up. Okay, here we go. And then you should be good with this.

MR. LYSS: Okay. I am Aaron Lyss. I am the director of strategy and business development with Tennessee Oncology. For those of you who are not familiar with Tennessee Oncology, we are one of the largest wholly physician-owned oncology practices in the country. We have over 80 oncologists including medical oncologist, radiation oncologist. We have our own specialty pharmacy as well as a phase I research program through our partnership with Sarah Cannon Research Institute.

My role there? I have been -- the four years or so that I have been there now, it's been primarily focused on finance related to value-based payment as well as supporting our operational initiatives in our value-based payment programs in which we

are participating.

So, I wouldn't refer to myself as an expert on the ACO program but I think there were some interesting lessons from that program that are relevant to the APM that we are participating in Medicare's Oncology Care Model as well as to MIPS. And so, one of the things I would point out -- does this thing work? No. Don't look like it does -- is, you know, you see, kind of, a -- you start see a spike in groups who were successful in this program once you get about two years in and then again at about the three-and-a-half-year mark.

So, I think, that just, sort of, illustrates the complexity of these, you know, new payment models, whether that's MIPS or whether that's a new APM and how long it takes organizations to, you know, to adapt without, sort of, multiple rounds of data and feedback loops, you know, in that experience. It's really hard to, you know, sort of, get to that point. These are organizations that self-selected themselves for having a high propensity for organizational change.

So, you know, in terms of, sort of, the impact of MIPS so far. I think one model, one framework we can use for that is to focus on the quadruplane. For a second, I am going to assume you all can see it, that workforce health is a, you know, a severe issue. I will talk more about that. I am sure, you know, we are going to talk more about that on this panel.

But in our analysis of the link between patient experience and these programs, you know, we found that, you know, it's -- the gains we have made in patient experience in our analysis of internal surveys are made despite these programs, despite the attributes of these programs and not as a result of those attributes. And I think that it's really, you know, sort of the responsibility is on proponents of these programs to justify the, you know, the cost to workforce health with the benefits to health outcomes in total cost of care that, you know, purportedly we should see these in programs.

So, you know, I think the high-level intentions in terms of increasing

provider consideration of costs of care and introducing performance-based variation in reimbursement, that's not a really sufficient justification for, you know, continuing these programs in their current form because there are other more effective ways that we can accomplish those, sort of, fundamental objectives.

I think we really need to -- the standard really should be higher order accomplishments such as feeling that reimbursement is commensurate with provider influence over outcomes and really showing that these, you know, if there are -- to the extent there are gains in cost of care and health outcomes that those cannot be achieved some other way through some other type of program that doesn't have the level of burden on workforce health as well as patient satisfaction.

And, I think, you know, we have created a system with these programs that is, you know, increases the perhaps satisfaction of public health researchers with the granularity of the data that will be available or for people who sell HIT systems at the expense of providers being able to look up from the screen. And, I think, that, you know, that's -- you know, we really have to be more thoughtful about how we are striking that balance.

And then, you know, in terms of organizational economics, you know, I would -- in one of the interesting things about the APM in which we are participating is that we are required to report how we are investing in that program each year. And, sort of, very quickly it becomes apparent in that analysis that the cost of FTE time, you know, far exceeds any revenues that we, you know, garner from the APM or from MIPS. You know, to the extent that FTE time is about four times the cost of the FTE resources or about four times the revenue from -- combined revenue from MIPS and the APM.

And, you know, I will concede that that's -- those are costs that we would, you know, we would take on to do something else, for some other types of activities as Kavita mentioned. But they are real costs to, you know, that we have to allocate -- real time that we have to allocate to these programs.

So, you know, I think, basically as we increase the, sort of, multi-dimensional performance evaluation all of the requirements that we have to meet that are associated both with our APM and with MIPS, you know, we raise the resource investment necessary to perform well in these programs and we reduce overall workforce health and, you know, I think so far, you know, those two things are way out of balance. You know, we can't measure everything, we shouldn't need to report everything. We really need to be more judicious in terms of focusing on, you know, what's really important and what's really going to move public health outcomes and total cost of care.

And so, I think, there was a really interesting article written by my co-panelist in health affairs that proposed, sort of, focusing on APMs as a potential remedy for some of these issues that we are seeing in MIPS. And, I think, that that, you know, that type of solution has a lot of potential but, sort of, similar to the gap between intentions and reality that we have seen in MIPS so far, we -- you have to get the structure of the APMs right in order for them to sort of render those benefits.

When the downside -- sort of the stop loss downside of the APM is 15 times the small incentive we get from participating in an advanced APM, we haven't -- we are not going to be driving provider organizations to those options in a way that we could if they -- if we balanced those issues, you know, appropriately.

So, I think that's as much as I cover for now and we will have time for questions.

MS. PATEL: All right. Thank you, Aaron. Let me get -- last but not least, Tim, to set up here. All right.

MR. GRONNIGER: All right. Good morning. Really happy to be here today.

So, just a quick note about me and Caravan Health. I work in Caravan Health and we are a company that helps health systems and physicians create and operate accountable care organizations as well as operate other value-based purchasing

programs. Before this job, I spent a number of years at CMS and on the Hill working on physician payment policy among other things. And so, I certainly -- I am happy to shoulder my fair share of the blame for the MIPS design and operations.

And so, what I want to talk about today is -- somewhere is what I think I heard from people representing physicians and provider organizations that MIPS isn't working if we were to define what we think Congress was trying to accomplish for the program. But I want to get to MIPS actually, I think, can't be made to work to accomplish the objectives that Congress laid out for it which, I think, if you listen to how people spoke about it, if you listen to -- if you look at the design of the program, it's really intended to drive quality improvement to drive attention to total cost of care in, sort of, like creating an alternative payment model for the entire fee-for-service program that is not in alternative payment models.

But it was also designed with an intent to differentiate the performance of physicians in trying to measure at a physician and clinic level their performance so that patients could be -- could use that information to choose physicians, high quality physicians and thereby reinforce quality improvement incentives. It is also intended to create incentive to join alternative payment models which are for a more direct and clinically nuanced way to support quality improvement and total cost of care.

And so, just to summarize why I -- what I think that we are hearing that the problems with the program today, it's very administratively complex and difficult to manage program from the perspective of a clinic or practice administrator that requires a lot of staff time to deal with. It requires a lot of investment in IT resources. What we didn't hear was MIPS has motivated me to put in place the best industry standard PDSA cycles to identify the major needs of my patients. I think what we see often is that it motivates the choice of the easiest measures.

And so, that's really where I am going to start of why MIPS can't be made to work. Congress laid out, in trying to maximize physician independence and

autonomy while also supporting quality improvement, a system where physicians and clinics would be able to choose the measures on which they are judged. It also allowed physicians -- it set physicians in a position of having these single highest stakes value-based purchasing program in Medicare. And these are the smallest actors of significance that we deal with from a Medicare fee-for-service position.

Medicare vantage plans -- effectively their value-based purchasing program is five points, in some cases it's ten. These are giant companies that have the ability to manage that risk in and to plan forward over a number of years, spending hundreds of millions of dollars in that process, while physician offices -- the theoretical plus and minus for them when you get out to four years implementation is minus 9 to plus more than 30. And so, that's a huge spread and, I think, looking at the negative is the cleanest way. But even minus 9 is a really big number for clinics in a context where you then ask them to turn around and to do real quality improvement work.

And as Shari described, the measured choices that physicians face, there is a huge number of measures to choose from and then in some specialty areas they feel that do not have enough measures to choose from. And I want to pull up a table from a paper that Kavita and I wrote along with Matt Fiedler and Paul and Lauren Adler and a few others around what is the operation of MIPS likely to look like over the early years of program based on what we knew from physician quality reporting programs that preceded MIPS and then essentially were rolled into MIPS.

And so, what we found is that if you look at this, there is strong incentive to choose the easiest measure possible resulted, even in a program where there was no attachment to your performance in PQRS. It didn't matter how your score, what your score was in PQRS, but even with that clinicians gravitated towards the easiest measures. And the number one measure by far in the program and still to this day is documentation of medications in the record. In many cases you could argue that that's effectively a state law requirement. We have this giant apparatus built up now spending

hundreds of millions of dollars at the Federal level and, you know, multiples of that in the private sector to encourage reporting of measures that are really easy in many cases or are -- should arguably be basically standard of practice.

Now CMS, I will note, is aware of this and is trying to rotate out top-down measures but for reasons of political economy -- I am going to talk about a little bit more in a minute -- that ends up being really hard to do in a sustainable way over time. So, with this really strong incentive to choose the easiest measure you end up with practices choosing the easiest measures of course. But then not spending that time focusing on real quality improvement but having their IT staff do quality improvement, turning it into a compliance exercise, not really looking at the total cost of care -- excuse me. Let me see.

So, the fee-for-service system that we have here, that Congress -- Congress really faced a dilemma in -- thank you -- in the design of the program here that I outlined around clinician choice and the impact of the program, right. So, the high stakes seems like, well, if you dealing with a minus 9 to plus 27 or plus 30, it seems like that's a pretty strong reason to do well in the program. But if you pair that with measure choice then you will have a really strong incentive to choose those easy measures.

The alternative to that is what is done in APMs or in some other context is to define a list of measures, public private cooperation, you know, lot of clinician input of course. But in an ACO context, for example, there are 30-ish measures that are reported. About 15 of them are reported from clinical data and the other half are reported from claims. And they are known ahead of time and they are curated and the organization can improve performance on them over time. Some of them are easy, some of them are hard but it's a back and forth.

Here you have got this situation where Congress in trying to put in place a high-impact program wanted to give as much choice as possible and undercut their ability to do that with the choice. This is not something that can be fixed by tinkering

because you are always going to be looking to encourage that choice and also because we have in our minds this -- if we put in place the right incentives for these organizations and they are going to figure it out.

But paying physicians is really a lot more like paying employees or paying a small, very small businesses in many cases. Not that physicians are employees of the Federal government, obviously that's not the case. But they are not in a position to put in place the business processes that a hospital is, say in the value-based purchasing context where they are able to invest significant resources in quality improvement on a defined set of measures over time.

And so, this problem becomes even more clear and our paper goes into this in more detail when you look at the construction of the cost measures that are an increasingly a large part of the MIPS program there. It started at zero percent in 2017 to up to 10 percent this year. CMS is proposing is proposing to take it to 15 percent for next year.

CMS has gone through three batches of proposed measures in three years for that part of the program and because you are dealing you have to account for very small practices, they are looking at measure thresholds of 10 cases per year for some of the new episode measures, 20 cases per year.

That is obviously going to be difficult to justify in terms of is that a good representation of any particular clinic's performance. It leads to huge disagreements with the medical community and it's not something that can be solved with statistics or simply trying harder. This is going to be intractable problem. You also have conflicting incentives in the cost domain where hospitalizations are counted twice because they are counted in multiple episodes. And so, it's truly a mess on the cost episode piece of the program.

And so, I am going to wrap up here so that we can get to questions. But as I said that this is something that can't actually be fixed by simply tinkering the way we

would normally try to improve some of the, say, innovations in our project can be modified every year or multiple times per year. Congress has revisited the hospital value-based purchasing program multiple times and it is functioning more or less as intended. Hospitals are tracking difficult, in some case, measures and improving on them consistently. We have seen reductions in readmissions. But it has also been tinkered with by Congress.

In the case of MIPS, the costs of the ongoing program are very large in terms of wasted clinical time wherever we have physicians working on this program instead of focusing on their patients' needs, significant administrative overhead in the private sector in particular and also some lost urgency around moving to better payment models and payment models that can be made to work better over time. So, from my perspective and that's argument to the paper, I still believe it's true, it's much better for Congress to get involved now and to greatly simplify the program, to forget about trying to connect performance on a this small and list of measure to large payment adjustments for physicians and move to a simpler set of incentives to promote quality improvement processes and adoption of alternative payment models. I am going to stop there.

MS. PATEL: All right. Thank you, Tim and we will go ahead and get started with just -- I know we have got about 10 and we will see where the conversation goes. Maybe 15 minutes, so that we can have a discussion. I am actually going to start - - I wanted to ask Aaron very briefly, just because I don't know if everybody understands but I would like for you to answer if possible at kind of a very granular level. You alluded to -- you are in both reporting on MIPS because you are also only in an advanced payment model, not in -- sorry, an alternative payment model not in an advanced alternative payment model to get that five percent bonus. Just given everything that you described, how hard is your organization going to work to try to get an AAPM designation or is that the goal. And you are speaking, kind of, not on behalf oncologists but certainly as specialists that are looking at opportunities. So, just very briefly, do you have a sense

of whether or not, as an organization, the AAPM looks more attractive, if possible to get away with this duality that you described?

MR. LYSS: Well, I think the way the -- there we go. The way the advanced APM, sort of, structure exists currently, I mean, I would hesitate to use the word 'non-starter' but, I mean, it's just -- it's completely draconian in terms of the potential losses that a participant could incur on the downside and, you know, compared to the potential upside of participation.

You know, having said that, we took the step of participating in a MIPS APM, you know, for the reason that we are committed to moving towards, you know, value-based care and value-based payment programs. You know, all of the practices who participate in the oncology care model, you know, presumably a lot of those in the other CMMI models, self-select themselves for, you know, their intention to innovate in that way. But you do, kind of, hit this road block when the numbers, sort of, add up, you know, the way they currently do in these, you know, with those two options. Is that what you were asking?

MS. PATEL: Yes. And then just very, also briefly, very briefly, the MIPS APM because you are reporting on both MIPS and you are doing the APM requirements.

MR. LYSS: Right. So, the --

MS. PATEL: How much time --?

MR. LYSS: -- through the APM, we don't have -- we aren't able to select the easiest measures for -- to hit. You know, the measures that we are measured against are, sort of, dictated by the structure of that APM. And the improvement activities are -- the most complex of improvement activities that we have to perform as part of the APM. And then we also have to do the advance in care. So, it's -- you know, we have the, you know, much more stringent limitations in terms of options for participation in MIPS but yet despite all of the -- yeah, you know, I should also mention that the clinical data reporting associated with the oncology care model is incredibly robust, it's very

cumbersome, it takes several FTEs, you know, working for several months to do that clinical data reporting. And then on top of that, we still have to do ACI portion of MIPS. So, it's, you know, I think that is one of the things that could be re-thought.

MS. PATEL: All right. Great. Valinda, you have made several points. One around, kind of, the challenges of rural practices. And then you also, kind of, alluded to the desire to potentially find an advanced APM just for the sake of getting out of some of these challenges. So, can you speak -- number one, just to clarify because I think a lot of people have a misperception that if you are 'rural' that you are really automatically exempt from these MIPS requirements. Do you mind just clarifying for the audience?

And then number two, could you also speak a little bit, you know, we can't -- Tim eloquently, kind of, described that MIPS can't just be tinkered with and it really does need to be replaced. And maybe describe a little bit about how operationally at a health system of, kind of, medium to large size, how are you thinking about moving forward, when you have to live in the current environment. Are you as a system trying to get an AAPM and if so, what is your forecast on when that might occur? Aaron, press off and then -- I know I think only one can -- okay, good.

MS. RUTLEDGE: Okay. So, we have found that there is certainly a significant number of rural providers that meet the exemption category. But we should not assume the vast majority of them are exempt from it. And so -- and even the ones that are exempt particularly if they -- those providers are not near retirement, they really understand that they need to get into the game. They need to understand how to work within this new environment. So, even if they may complain about it, when you go into their office and, you know, they roll their eyes and say, there goes the government again, you can imagine some of the conversations we have, the vast amount of them say I need get an EMR. I have got to figure out how to work within this.

And so, one of the things that we have found is they are eager to join CINs to help them because they understand that they need assistance. Now I do know

CMS has provided some of that additional assistance but it's not at the level I think that many of the rural providers are feeling comfortable with and it's certainly not the level that somebody that's in their own town and goes into their office and drives to the rural city and sits there that they can provide. So, with that, many of the rural providers around us have been very interested in being a part of the CIN so that we could assist them with that.

We made the decision to go with an advanced APM of track 1 plus. We selected the ones -- we selected the one that had the least amount of downside risk. You can imagine with 2,800 providers and 30 to 35 percent of them in rural areas, we went to something that had the least amount of risk. And we are really glad that we made that decision after getting our 1.59 percent --

MS. PATEL: Bonus.

MS. RUTLEDGE: -- bonus. And I will tell you --

MS. PATEL: But you made that decision without knowing that that was your -- right.

MS. RUTLEDGE: That's right.

MS. PATEL: So, you had to make the organizational decision.

MS. RUTLEDGE: We were making it on the assumption that we would get around three percent.

MS. PATEL: Interesting.

MS. RUTLEDGE: We didn't think at a 2,800-person system that we would probably reach the top at four percent. So, we were anticipating, we would come in between 90 and 95 --

MS. PATEL: 95.

MS. RUTLEDGE: -- and spending, you know, millions and millions of dollars. We probably spent close to seven to eight million dollars in helping the system, the CINs comply with it. And we, as I said, 60 cents on the dollar. So, you know,

certainly a five percent bonus will help off a set that -- particularly from the employee docs, the independent docs and the rural providers will get that directly themselves. But that five percent bonus will, from the employed docs, will help the system as a whole offset all that investment we have put in for the system as a whole to move up -- that CIN to move up in terms of competencies, in terms of population health.

MS. PATEL: Great. Shari, you spoke about a number of activities. Obviously, the ACPs sounds like you are supporting, kind of, quality improvement programs and more, kind of, collaboratives that are -- it sounds like they are more meaningful. How, kind of, thinking about what Tim mentioned with the struggle from a policy perspective with including a lot of measures for the sake of political economy -- how can we transition potentially? Do you see an opportunity to take the, kind of, meaningful activities that are coming at the ground level which I have been, kind of, using for the, kind of, clinical performance improvement activity bucket in terms of meeting MIPS requirements? Is there something that should be translated into the broader quality measurement requirement or some way forward because I know when we have spoken before, we have all said, we are not in love with MIPS but don't throw it out without thinking about what you replace it with, which is also something Tim echoed? So, what is it that we can do to bridge what you see happening on the ground and what we see at a policy level?

MS. ERIKSON: Sure. So, I think that a lot of what's going on on the ground with some of the quality improvement activities are improved quality improvement programs that are going on are really tied in to clinical guidelines and measures that have been viewed as valid. And I think one of things that I think we could do and I hear what Tim is saying about the issue of we can't just tinker with the program, I actually think there is a quite bit more flexibility than might be viewed, so to speak, by some in terms of what the law lays out in relative to what we can do.

I think that we need to be pretty open-minded about that. So, if one were

to think about really taking a quality improvement activity which includes the activity, right, that component of it. Most of the times those activities do include using health IT in a meaningful way to do that work. They also include the measures, right, because you have to have measures to be able to measure whether your quality improvement activity or quality improvement program is working.

They also include looking at the cost for the most parts. So, these programs are looking at those components. How can we have those types of efforts counter cross it all? I mean, that's, you know, that's really what's intended here, right? We had separate programs, we had value-based program, we had PQRS, we had, you know, whatever else. We had meaningful use, that's it. So, we had all these programs that were intended through the law to be brought together.

But I think that, you know, we still have, in many ways, four silo-ed programs within MIPS. And I don't think it has to be that way. It just doesn't. The law doesn't say that it has to be that way. So, I think that's we need to do is be thoughtful about that.

Let's look at how we can actually have things that individuals and programs and practices are doing and give them that credit across that. Maybe it's through even things like safe harbors for those who test this out for the administration to give them, you know, ideas to be able to translate this into the policy that's needed to do it. I think that's one, you know, practical way we could think about it and there are probably a number of others, but I will stop there.

MS. PATEL: No, that's great. Thank you. And then Tim, I am going to give you a two-part question, but I want to, well close with a very rapid fire panelist question. Our title of our talk today or title of our program today is 'Can MIPS be salvaged?' Sounds like maybe the answer is yes. Let me ask a different question. Were we better off before with those separate programs? And everyone is saying no but let me -- if I will just get to that and if you say -- since we are all going to say no, let me ask it in

a different way. Were we -- are we better off trying to actually do what Tim suggested where we need to probably replace the program or do we think that we can do what Shari described with, kind of, taking pieces of it and looking at how to just make those pieces work in harmonization, et cetera? So, I am not going to load your answers.

But Tim, two parts. One, the first thing, you described, kind of, working -- I think your organization works pretty critically with accountable care organizations of maybe different types. So, I am not sure if they are all risk bearing or, kind of, heterogeneous. Again, this question of do you think that and largely not hospital-owned. I am just going to venture just knowing what I know. Do you see a trend where these organizations see their path forward as Valinda described, kind of, in an AAPM, maybe a higher level ACO that's taking risk because that is one way to, kind of, keep moving along the continuum?

And then the second part, I can remind you if we forget, is really around, kind of, in the backdrop, the trend towards consolidation which is occurring across primary care and specialties and certainly have -- I don't see that slowing down but you should tell us whether or not you think some of the, kind of, aspects that we have been critical of, of MIPS today might unintentionally drive consolidation in the provider market as well.

MR. GRONNIGER: Yeah. So, I will try to answer the first one quickly. So, we work with different types of ACOs including hospital and hospital physician partnership ACOs and many of them, you know, are in ACOs partly because MIPS is so annoying to deal with, right? And so, but many of them are looking at the future and saying CMS is going to be making us taking risk, we better practice doing that. And, you know, seen as a better way and more stable way to work on care improvement and total of care management.

I think that the question around consolidation is a little bit separable from MIPS in the sense of Medicare has to figure out what it wants to pay for, define what

counts as high quality, define what counts as reasonable and efficient payment rates and pay that. I think Medicare is in some cases looking at side of care differentials where, I think there is a pretty strong argument that payment differentials have led to consolidation though it should be cleaned up that that sort of separate from MIPS.

I think that you need to get the definition of what you want the program to reward straight. And then empower people in the private sector firms, people at hospitals and physician networks, and all across the system to figure out solutions that are going to be efficient for them and for their patients, rather than micro-engineering it like I think we do in MIPS.

MS. PATEL: Right. Okay, great. So, I have taken the moderator's prerogative of changing my lightening round question. So, what is -- since we are going into the next panel to talk about, kind of, solutions and strategies, each one of you have mentioned several in your presentation. If you were, kind of, sitting at CMS today, you have heard all this feedback. Certainly, there is the physician fee schedule rule which has some provocative changes to ENM that, I think, are also going to color a lot of how we feel about MIPS to be perfectly blunt. What is, kind of, the one top priority in 'salvaging MIPS'? So, it could be anything and even a repeat of what you said but just the, kind of, the top thing.

I will go first. I will say to expand the opportunities within advanced alternative payment models, much more broadly, including opportunities for primary care. One has argued that ACOs offer that. They don't make sense for everybody but expanding that portfolio in a meaningful way and harmonizing that with the MIPS requirements. Valinda?

MS. RUTLEDGE: Yeah. My comment would be, don't try to tweak a program that is not working. I think that's always not a good time proposition for us in this industry. And I think we need to look at where we want to end up at. And focus on modifying the program for that. And if we feel that population health risk-based contracts

do improve the health of the populations that we all serve then that should be the end point in terms of the modification of the program.

MS. PATEL: Great. Shari.

MS. ERIKSON: Sure. So, I think that you have to invest in making improvements in the current program because we have the current program. And but at the same time, I like what Valinda just said though about let's look at where our goal is and let's make those changes to it looking toward that goal. And I do think that what you and Tim wrote about in that article is very important that there need to be more opportunities for clinicians, physicians to design and implement and be part of advanced APMs that can offer them really much more meaningful chances, I think for making quality improvement and being rewarded for that quality improvement.

MS. PATEL: Great. Thank you. Aaron.

MR. LYSS: Yes. So, I think -- oh, now it's on. Yeah, I think you have to make the performance evaluation portion of the, element of these programs fair for, you know, they have to be highly targeted as we have discussed, and they have to be understandable at the point of care. The more understandable they are at the point of care, the more successful they are going to be. And, I think, you know, we have to leverage some of the work that allow the professional society quality programs have done.

And, you know, it's not a matter of, you know, getting rid of MIPS and replacing it with nothing because we already have things to replace it with. We have professional society quality programs, you know, we have -- you know, a lot of organizations across the country now are publishing case studies of their quality improvement efforts. You know, we have done that in areas of pathways and appropriate bio-marker testing and responsiveness to patients via, you know, validated symptom management triage protocols.

All of these things that can, you know -- the folks who, the care teams

understand and see the value of them and, you know, while meaningfully improve care, you know, when you take away some of the burden -- the reporting burden of these programs, you leave more space for those types of initiatives.

MS. PATEL: Great. Thank you. Tim, final word.

MR. GRONNIGER: Three things. Although I would first say, I think, it's mostly on Congress to fix the structural problems. It's not the CMS.

MS. PATEL: Right.

MR. GRONNIGER: I think, CMS --

MS. PATEL: So, you are in Congress. Sorry. You can personally be a member of Congress. Yes.

MR. GRONNIGER: No, I have already got my CMS answer. I can't change right now. The CMS needs to do what they are already doing in terms of reducing the administrative drag and cost of the program. It's got to be continuously made easier to deal with. They need to get rid of the easiest measures. The least important measures for patient care. That's going to be hard. They are doing that a little bit but I think that there are too many measures in there that are not meaningful for patients. And they need to invest in alternative payment models like you said development. But also, incentive for joining wherever they have levers in MACRA, I think that they need to leaning it to towards APMs rather than MIPS.

MS. PATEL: All right. I know we could go on and on. We have a great next panel so -- we short changed them just a few minutes but thank me -- join me in thanking this current panel and we will switch out pretty quickly.

(Recess)

MR. GINSBURG: Okay. I would like to begin our second panel. And begin by introducing -- you could take seats, please. This is the order in which panelists will speak. We are going to start with Jim Matthews who is executive director of MedPAC and he will describe the Commission's analysis and its recommendation on MIPS and

anything else he would like to say. And hear from Matt Fiedler, fellow in Economic Studies at the Brookings Institution and who worked with Tim Gronniger to lead the analysis of the USC-Brookings Schaeffer Initiative for Health Policy work that Tim put up in his slide. Then we will hear from Sarah Levin who is a member of the Democratic Staff of the House Ways and Means Committee. And finally, from Robert Horne, now with Leavitt Partners but who served on the Republican Staff of the House Energy and Commerce Committee when MACRA was developed. Jim.

MR. MATTHEWS: First, I would like to thank Paul and the staff of Brookings for putting on this event and for inviting me. I am privileged to be here and thankful for the opportunity. I also, unlike the previous panel, I do not have slides. So, you are just going to have to watch me talk for the next five to seven minutes. So, I apologize for that.

MR. GINSBURG: That's the case with all our panelists. I discouraged the slides.

MR. MATTHEWS: But it's a very nice background slide. So, that should take some of the strain off. And what I would like to begin with is, I had originally prepared two presentations in response to the question of this forum, 'Can MIPS be salvaged?' And the first one went something like this. No. I am happy to take any questions. But in the interest of developing that thought a little bit further, I do want to represent MedPAC's current position with respect to MIPS and spend a few minutes talking about the evolution of our position.

So, we recommended eliminating MIPS in our March 2018 report to the Congress. Some of you may have heard about this. But I am going to rewind for a little bit and talk about the origin of that recommendation. And it begins with recommendation we made seven years earlier to the Congress that the SGR system be eliminated. This was something the Commission had felt very strongly about over the years in terms of its impacts on physicians' willingness to treat Medicare beneficiaries and fully engage in the

Medicare program.

And so, in 2011, we made a recommendation that included, you know, some fairly draconian payment updates for, you know, the decade ahead. And it was an indication on how strongly the Commission felt that the SGR needed to be eliminated. Congress did indeed eliminate the SGR in the MACRA legislation and it was a tremendous accomplishment. We, again, were completely onboard with the notion that SGR was serving no useful purpose. We also were very supportive of the new path laid out in MACRA with respect to alternative payment models as a mechanism to incentivize and help physicians engage in delivery system reforms. So, very supportive of that effort and we are continuing to develop ways to improve the AAPM process.

Then we get to MIPS and MIPS, we were fully onboard with the notion that there should be a value program available to non-organized, non-AAPM physicians. Many of our Commissioners over the last several years had expressed this sentiment in very clear terms. And so, we are very much in agreement with the goal. But over the last two years, we have come to the conclusion that MIPS is simply not going to achieve those goals. And spend the next couple of minutes talking about why we believe that.

When MIPS was first proposed on a regulatory basis in 2016, the Commission's position was that we would, you know, help CMS try to improve MIPS. But even at that point, we were raising some concerns about how it had been articulated. And we suggested focusing more on outcomes, measures, reducing burden by using claims, measures and a number of other issues. But we still started to raise some doubts about, you know, the viability of MIPS as a broad quality improvement program for non-AAPM physicians.

And over the following two years as the agency continued to roll out regulations refining the program, our concerns became even more pronounced and we ended up concluding that MIPS is simply fundamentally not fixable as a broad value program for physicians and there are a few reasons for this. And I want to emphasize

here broad value incentive program for physicians.

First of all, there are numerous statutory and regulatory exclusions to the MIPS program. By rough estimate we think currently 600,000 physicians are excluded as a result of regulatory decisions that the agency has made and another 300,000 or so are exempt by statute. So, almost a million are exempt compared to little less than 600,000 who are subject to participating in MIPS. So, in terms of a broad program to incentivize value, we have left two thirds of your non-AAPM physicians, kind of, off the table right out of the gates.

A second concern that we had is with respect to the small end problem in statistical reliability that given the fact that you are talking about measuring the performance of individual physicians, even individual physicians who are subject to MIPS and who are selecting their own measures may not have sufficient volume to have those -- their performance assessed in a statistically reliable way. So, you are starting to move Medicare dollars around on the basis of random variation and that's a point I am going to get to in detail in a minute.

We also, had concerns about the low performance thresholds that -- I think the minimum performance threshold now is 15 percent and the exceptional performance threshold is currently 70 percent. And I don't know about anyone in the room but if one of my kids came home with a 70 percent, you know, average on their report cards, I would not call that exceptional performance. So, we are talking about a very very low bar for purposes of again moving substantial quantities of Medicare dollars around.

We are also concerned about the fact that as currently constructed physicians will select their own set of measures and this creates a couple of problems. One, you cannot equitably compare the performance of one physician to another and again this is a fundamentally unfair prospect again with respect to Medicare identifying one physician as being better than another one and therefore you are going to get more

dollars than you over here. Not you personally.

So, there is also the problem of physicians selecting their own measures and they will likely, or at least this is what I would do, select measures where I would have the best chance of performing extremely well. This is just human nature. So, what's going to happen is you are going to get measurement compression where you are going to see a lot of physicians performing at, you know, the 98th, 99th percentile on their different measures and as a result, performance good or bad, is going to be assessed on extremely fine gradations within, you know, a very high top of the spectrum in terms of their scores.

And this is going to, you know, it might not make much of a difference now when the payment adjustments are, you know, in the one-two percent, plus or minus range but when you start getting into the negative 9 to plus 30, this is going to make a real difference. And as, you know, MedPAC has talked to different physicians out in the community, one very compelling anecdote we heard was, how do I explain to my family that I have just taken a 20,000 dollar pay cut due to random variation. Big problem here.

And then there is also the question of burden. So, I think, virtually everyone on our previous panel mentioned burden, no benefit relative to the cost, no return on investment and CMS estimated close to a billion dollars in compliance costs in the first year of MIPS and we are projecting half a million dollars annually in compliance cost on an ongoing basis as long as the program exists. And again, this is for a program that is not going to really measure performance at the individual clinician level.

And, you know, a lot of the advocacy organizations will argue, we have spent a lot of dollars, we have made a lot of investments into this, we can't stop it now. But, you know, how long do you want to keep throwing money into a program that, you know, is not going to fundamentally achieve its goals. And at the same time that some of the advocacy organizations are making this argument, others are, you know, having campaigns to their members that say, you know, one measure, one patient, no penalty,

which in my mind does not sound like broad-based quality improvement and incentivized, you know, value on a broad basis.

So, on the basis of these concerns, MedPAC recommended in March of 2018 that MIPS be abolished and instead replaced by something that we call the voluntary value program. I am cognizant of the fact that I am running long on time, so I won't go into it in tremendous detail. But under this construct, groups of physicians can volunteer to be measured on a small set of, you know, a population-based outcome measures similar to the measures that we have in mind for AAPMs. That's an important point.

And under this construct, it solves at least four major problems with respect to MIPS. One, it solves your small end problem. You can only be measured if you have got a sufficient number of participants in your group. Two, it solves the burden problem. There is zero burden to this approach. Mostly these measures are claims based which would be calculated by CMS or there are patient satisfaction measures through exogenous surveys that could be used. It solves the equity problem. Each group of physicians is going to be measured on the same set of measures. And again, there is numerous questions and concerns about what MedPAC has proposed and I could take that on question.

But the last thing it -- well, second to the last thing it does is it solves the value program. The measures that we have in mind are not things like, are you adequately assessing your patient's blood pressure on a regular basis, but they identify things that are important to the Medicare program and its beneficiaries. And then lastly, this approach does provide an on-ramp or some, you know, set of training wheels for clinicians to come together as groups on an informal basis under our construct but since they are going to be measured on the same kinds of things that, in our vision, would apply to AAPMs, this does allow them to, kind of, try it out before deciding to go that next step and take on risk before the cost and quality of care for their aligned populations. So,

with that I will stop talking and turn it over to our next panelist.

MR. FIEDLER: So, given that, as Tim alluded to, he and I have, along with Paul, Kavita and a couple of other folks here at Brookings, co-authored some work on this topic, probably won't surprise folks that I am also on team 'let's abandon MIPS'. Try not to repeat what Tim said but, I think, there are three basic points that drive me to that conclusion.

I think the first is that the empirical evidence more broadly on, sort of, value-based purchasing and pay-for-performance type programs that measure clinicians on a range of different cost and quality measures and then adjust fee-for-service rates upward or downward on that basis is just very weak. I particularly like there was some recent work by Eric Roberts and colleagues on the value modifier which was a predecessor program to MIPS, that looked to see whether there were changes in physician performance at practice size thresholds where practices became eligible for bonuses or became eligible for bonuses and penalties under the value modifier which was a predecessor program to MIPS that looked to see whether there were changes in physician performance at practice size thresholds where practices became eligible for bonuses or became eligible for bonuses and penalties under the value modifier. They found that there was no evidence of changes in performance at these practice sized thresholds which strongly suggest that these types of incentives were not in fact changing behavior.

And that's not unique finding to the value modifier. Lots of the research on these types of programs including the hospital value-based purchasing program and others finds these programs to be fairly ineffective tools for changing behavior. So, that leads me to believe that MIPS likely to go down a similar road. Now, you know, perhaps you thought that these reflect fixable design flaws in these types of programs. I think for a variety of reasons that other people have touched on, I am not optimistic on that front. I think the small numbers program and that both Tim and Jim alluded to is, it's just sort of

fundamental here. You are going to have -- when you are trying to clinician or practice level quality measurement you are just going to have very noisy measures and that's going to mean the, sort of, amount of incentive kick you are getting for the amount of risk you are exposing providers to is just not a very attractive tradeoff.

I also think when you are in a world of clinician or practice level payment adjustments, it's very difficult to create a coherent set of financial incentives that way. You know, I think, in the MIPS cost domain we have great example of that. We have a need to measure lots of different types of clinicians and so, you know, the approach CMS has taken is do a bunch of different cost measures, throw them together, average them together and that's your score but because each dollar is going to -- depending on who meets sample-size criteria and which measure you are using, each dollar is going to be counted -- each dollar spending is going to be counted multiple times or not at all. The overall set of incentives were creating the, sort of, think about the overall cost of care is pretty haphazard and scattershot.

That may -- some of that sort of problem may actually explain part of why these programs have been ineffective in that it's the scattershot set of incentives makes it hard to providers -- for providers to figure out how to respond to them. It may also mean that even if providers did figure out how to respond to them, we wouldn't be thrilled with the types of responses we saw.

And then I think the -- you know, so if we have a structure that we think is unlikely to work based on prior experience that we probably can't fix, I think -- other people have alluded to the fact it's not possible to operate this program. So, you know, those administrative costs might well be worth paying if we thought we were causing real changes in quality or reductions in the cost of care in a world where we are operating a program that seems to be pretty inert, they are very difficult to justify paying.

So, for those reasons, my view is that the evidence justifies abandoning MIPS but if we were in a world where Congress were taking action to repeal MIPS which

may not be the near-term world we are living in but maybe we will be in the world someday, I think this would be a good opportunity to implement other changes that might reduce the cost to improve the quality of the care. I think that probably will take a lot of different forms, I think as we move forward there has been a little bit of a focus on silver bullets and in fact we are probably going to be looking at, sort of, multi-factorial approaches to deal with many of these problems.

But I want to focus on steps policy makers could take to make alternative payment models more effective in Medicare given that APMs were the other main reform pathway that was envisioned in MACRA. So, in contrast to the value-based purchasing programs, my read of the evidence today on APMs leads me to be cautiously optimistic that these can be effective tools. On the bundle payment side, early evaluations of CMMI's voluntary bundle payments program may mean -- voluntary bundle payment programs seem to suggest that these models can generate modest savings with impairing quality though there does seem to be some variation from episode type to episode type with surgical episodes I think at this point having stronger evidence of effectiveness.

On the ACO side, I think, the best work is probably by Michael McWilliams and colleagues looking at performance in the Medicare Shared Savings Program that again seems to find modest but what I would call meaningful reductions in spending under ACOs alongside modest quality improvements. For a variety of reasons, my suspicion is that as providers gain experience with these models, the savings will likely grow and I think there is also some reason to believe that as these types of models scale there might be systemic changes and, sort of, how medical practice and even medical technology involved that would mean that their long run impact could be larger than what we are able to measure in the short term.

So, that's why I think this is a valuable road to go down. What do I think the, sort of, useful role for policy is beyond what we are doing now to make that possible?

This is where I get a little more radical. I think one of the major barriers over the medium term to realizing the full potential of these models is that they are right now for the most part purely voluntary. That creates, you know, a number of challenges but I think the biggest one is how to set provider spending targets so that benchmark spending, benchmarks in ACO models or the target prices in bundle payment models.

You know, initially these models have solved this problem by setting the spending targets based on providers own historical cost experience. And that's a great place to start but it's not a viable strategy. If you are a provider that's recognizing that, wait, if I save a dollar today, then when they reset my benchmark in a couple of years, they are going to look back that I successfully reduced costs before and so my future spending targets is going to drop by a dollar.

That's not a particularly sustainable financial model. It's not one that creates strong incentives. This approach also tends to lock in historical cost differences which is going to reduce the incentives for efficient providers to expand and serve more patients and weaken the incentives for inefficient providers to contract. The problem is that the natural alternatives to that approach in the context of voluntary models have some real challenges associated with them.

I think the most natural place in the place that I know MedPAC and others in the context of ACOs has suggested going is to set spending benchmarks, for example, based on regional average spending. The problem with that is in a purely voluntary model providers with above average spending are likely to drop out of the model, providers with below average spending stay in the model and realize big windfalls. So, I think, that does mean that over the medium run, if we really want APMs to be our key strategy, we are going to have to make these models less voluntary. That can, I think, be, sort of, combination of carrots and sticks and I think depending on the model, the right approach is likely to differ.

On the bundle payment side, I think, the right approach is probably

ultimately going to be where we have models that we think work actually making them mandatory. On the ACO side, it's not at all clear what it would mean to make ACOs mandatory or how you do it. So, I think, they are building on the bonuses for advanced APM participation that we are in MACRA is really the right path forward.

So, I think, step one is just to make sure that the five percent bonus doesn't go away in a few years. But I think beyond that, we should be thinking about making the financial incentive to participate larger. So, we would envision doing that through a budget neutral combination of bonuses for the participation and potentially ultimately penalties for non-participation. I think it is also a question whether those bonuses should be limited just to physicians as the APM bonuses under MACRA were or whether we should be expanding those to additional types of providers in order to expand the, sort of, set of providers that has a stake in making sure that these types of models are operating in any particular community. So, look forward to the conversation.

MS. LEVIN: Hi. Thank you very much for having me here. I need to start with the disclaimer. The views that I am about to speak are my own. They are not necessarily those of the ranking member of the Committee on Ways and Means nor are they necessarily the views of the members of the Committee.

So, onto that. I think that Paul and Jim touched on this, but it bears repeating, stepping back a little bit and remembering where we were couple of years ago with near-constant conversation of the sustainable growth rate. And, you know, SGR was started, as was discussed, in 1997 and since the early 2000s, there were repeated and regular cuts that were going to hit physicians that Congress had to stave off. And this would bring physician to physician communities to Congress saying, please don't have these cuts and beneficiary groups saying, please don't cut my physician payments, I want to make sure I can still see my physician and be able to still see my doctors. And the conversation in healthcare was largely -- in the Medicare space -- was largely talking about how to get rid of the SGR and how what we can do next.

And so, over the course of that period of time, Congress spent about 170 billion dollars on short-term patches. And in 2015, the physician community was facing a 21 percent rate cut. And so, in comes MACRA and in the time post-Affordable Care Act this hyper-partisan healthcare discussions, here is this bipartisan work that is looking to talk about value of care and drive.

And the whole point of MACRA and, you know, MIPS and advanced APMs was to talk about how to move to a system that rewards value of care instead of volume of care. And that's a change of conversation from, you know, sort these cuts to how do we move to value. And it's reflective in this community right now to talking -- we are talking about how do we make sure that we are improving care for beneficiaries and doing it in a meaningful way for the -- an easier way for the physician community.

So, Congress established MACRA which created this two-pronged approach. One is the advance alternative payment model for those who are willing and able to take on risk for their payments and those large section of the physician community who was maybe not quite ready to take full on risk but, you know, maybe interested in value.

And we heard loud and clear from the providers that not every doctor is the same and there is variation in the readiness to move to value, there is variation in size of practices. A one-man shop, there is several hundred person shops, there is location that, you know, what is in -- what a physician practice in Iowa or Tennessee, it looks differently maybe then one in New York City or Houston.

And so, there is also the physicians who come and say, you know, I am different from another physician. You are going to measure my quality. I am pathologist, I don't see patients. How are you going to change my payments? I am a family practice physician so I care about, you know, these flu shot measures are relevant to me but a surgical measurement isn't relevant to me. So, how are you going to make sure then any value proposition can speak to me?

And so, there are a lot of challenges and since the physician community is diverse both in, you know, size, scope, geography, with types of services that they furnish -- you know, trying to make a program that encompasses this all and -- you want to make sure that there is opportunities for everyone to succeed and to continuously push towards that value.

And so, MIPS is an important part of that package tool to lead towards an on-ramp for those who are may not necessarily be ready to move to value and then in 2015 or really the onset of MACRA which started in 2017 than giving people the opportunity to do so. And this is -- it's a marathon strategy really and there are those who started who are more integrated practices who have been doing this -- bearing risk for quite some time. Started at mile 26, I only had .2 to go and really, you know, understand and have the systems and capabilities in place to move towards that value in a more advanced way and then there are those who are not even at mile 1 and we, you know, need to have a set of systems so they keeling over before they get to mile 10 or 4.

And so, you know, there are those who talked about here in the earlier panels that there is MIPS' -- can be used as an incentive to move towards that advance APM. And that's really the goal to try to get everyone in on-ramp or movement towards those advanced APMs.

And there has been a lot of concerns that are valid, that have been talked about and they are continually talked about here and in Congress, how do you measure performance in a meaningful way? How do you continue to push the outcome space measurements that are meaningful for physicians, that are meaningful for patients and saying how can I improve care? Or what type of care am I going to receive?

And that is an ongoing process and something that needs to continue to be developed and moved on. But I will say that right now in Congress that's the conversation, is how can we make these improvements, how can we move towards more value, how can we move towards outcome and the conversation has not yet been how to

dismantle MIPS.

And I think that, you know, just remembering that this was the -- MACRA, MIPS and advanced APMs was a bipartisan solution that came after over a decade of short-term patches and a long-broken system. And this is year 2 of the program. MIPS really started in 2017 and we don't even have the results from the first year --payment consequences haven't started. They don't start until 2019.

And so, we don't know how the program is working. We are very interested in how the program is working that we have had -- I mean, in our Committee, we have had several hearings on the implementation of MACRA. We had one earlier this year. Energy and Commerce Committee is having one next year. Congress has invested in making sure that it works and that it could be useful. We have made some changes, technical changes earlier this year and the bipartisan Budget Act specifically dealing with providing more flexibility to physicians and more time to on-ramp and to clarify some terms we are confusing and wouldn't allow the flexibility that we want physicians need to use.

But additionally, there were clarifications relating to the development of new advanced alternative payment models and making sure physicians have technical assistance to get to the point of developing those value-based models that both the physician community and, you know, beneficiaries want to see. So, we do want to -- the whole idea of this is to lower cost and improve quality.

And so, you know, I think it's very important to hear all the perspectives on the different challenges and I would say that, you know, the statute is pretty -- there has been a lot of regulatory issues that have been discussed here and I appreciate the discussion that when Shari talked about there is lot of flexibility in the law.

But when we talk to the physician community and the beneficiary community, they are not coming in and banging down the doors to repeal MIPS right now. They -- as in the way that they were and SGR. They are coming down talking

about how can we -- I need an advanced alternative payment model, I don't have one, how can I get one? And that's a good conversation to have. How can we make the measures more relevant? How can we drive to allow more people to have the ability to bear risk and to do more advanced alternative payment models and to even do the alternative payment models that hopefully lead down the road to those advanced alternative payment models?

And so, this delivery system focus is important. And so, we can bring everyone down the road, MIPS and using that on-ramp to get to the point where we can have those bearing risk discussions. Because again that small rural practice or small urban practice is very -- they are very different than the large integrated medical practices that may have -- that have all the data analytics and so moving everyone along is really the goal. So, I will stop there and turn to Robert.

MR. HORNE: Well, first and foremost, happy Friday everybody. Look I had talkers. I have completed iterated around those now so let me just start this way and I will, kind of, go back and forth.

First off just let me note, I am a Chicago optimist. It's a tough value proposition living in a town of absolutists but -- it was a bad joke, by the way. I want to switch the question around a little bit that we were posed today. And I want to first talk about how MIPS and larger than that physician reporting can be improved and utilized as a tool of driving value. And I don't want to answer whether MIPS can be saved or not.

Two things to note and really one to build off of Sarah. MACRA was a bipartisan law. It's still a bipartisan law. That's a really important part in this town and point in this town because modifications, improvements in areas to support the law are still very bipartisan. But as we think about basically MACRA and the role of physician reporting in a value proposition, it largely MACRA was created to get away from the SGR budget tool that was utilized around the inflationary updates under the physician fee schedule. And it was created to allow the physicians to help drive value in the Medicare

program where before some might have thought of it largely as an ACO proposition. And so, you could think about MACRA, one, as helping the physician community drive what the future of value looks like and it's something that is still a very bright proposition.

But number two, it could be thought of as defining the ways to measure those value propositions. And that's largely what you could think as MIPS and the APMs. APMs are the value proposition. MIPS, in some respects, are ways to measure that value proposition knowing that reporting is going on in an APM as much as it is MIPS.

In my humble opinion, MIPS is not just a measurement tool though. It's also an opportunity for data aggregation, gathering and the effective appointment or employment of data to support the identification and adoption of value propositions. My dad basically bought a new car first year model when I was six years old and he was so excited. He brought it home, he was bragging about it, six months later that car was no longer in our front driveway because it had problems. It broke down basically and it got fixed. Funny thing about the car, it's a MIPS analogy obviously, is that it was back in the driveway three weeks later and it worked well. It really did.

To Sarah's point there are a lot of flexibilities in the MIPS program itself that can be utilized to improve physician reporting as both an opportunity to define what measurement looks like but also as an opportunity to give CMS, CMMI, and others the data that it needs to identify and define what value propositions look like. We may not necessarily be utilizing those tools as effectively as we can but the flexibilities that Sarah spoke to can do that.

One example and Shari brought it up. The combination of CPIAs and the re-rating of measurement, measurement categories within the law, if combined, can help define what new value propositions are from a measurement standpoint and also potentially an APM standpoint.

Those aren't the only flexibilities. There are -- there is lot of flexibilities. If you consider too the flexibilities that CMMI affords the administration, you can almost

double those opportunities. Congress as well is not a passive participant in this. My guess is if somebody walked forward with a way to make the MACRA program more meaningful that wouldn't be a conversation that they would shut down. And I am not speaking for them. Sarah can speak better than I can. I no longer work there.

But in thinking about basically MIPS in some respects too, let's think about the role of physician reporting beyond MIPS. Physician reporting can be a way to really identify what new value propositions are in the APM pathway. One of the areas of improvement that could be focused on are opportunities to tie the MIPS pathways closer together with the APM pathway. And it's an area of policy that I am working on with a broad stakeholder community because I do believe that MIPS can be improved upon. I don't believe in the absolute statements that it should be gotten rid of. I think for anybody that points out a problem with the MIPS program, I would encourage them to think of a solution, not necessarily just say let's throw it away.

And again, MIPS and the MACRA statute are not an SGR budget tool. They really are ways to harness and drive value. But one example proposition reporting can be utilized better under the MACRA statute to drive our identification, adoption and use of value propositions in the Medicare program is to allow physician reporting to report more on what we could call prototypes of what measures look like and what APMs might be. And APM largely is a behavior change, some other stuff wrapped around the middle and a payment change. The proposition is based on if you accept more risk, we can allow you to do things in a different way that bring value to us all.

CMS, largely right now, CMMI and others, they need information, they need data. They want to figure out what works and what doesn't. One of areas under the MACRA statute right now that was designed to deliver data to CMS, CMMI and CBO was PTAC. Now it was envisioned much different than it ended up and it ended up where it was because staffers had divisionary ideas of what pathways could look like and we ran into the realities of CBO scoring and rightfully so, I think, pointed out some of the flaws and what we

had considered.

But the point is there could be a second reporting option. There are flexibilities to implement it that would allow physician organizations to put forward prototypes of what an outcome measure could look like, of what an episode could look like or what an APM could be.

Identify ways to report on those prototypes that facilitates the data gathering for CMS and CMMI to help them better understand whether there is a value proposition that is worth exploring for purposes of payment. If you use the physician fee schedule to do what -- in reporting, you get to do something interesting. You don't have to apply payment consequences to it which means largely every physician in this country could be reporting on a prototype.

The information that they are reporting would help inform CMMI as an example but what projects it should select with a goal of being more accurate in terms of the projects that it does select. In areas where the proposition fails, we have also largely succeeded because CMS and CMMI now know what doesn't work but they may be able to extrapolate from the failed what might work in the future and then put it forward again.

And lastly, you have increased provider confidence in the MACRA statute and found ways that they can better align their incentives with CMSes around identifying what the future of value looks like. The reason for the bad analogy on my dad's car was largely because MACRA is my dad's first year model car. It didn't work. I mean, it was -- self-edit. It was not a great car. But the thing is that car was in my family for 12 years after it got back from the shop and it really didn't have problems. The funny thing is, and again I mention the auto maker, but model year 2 and 3 and 4 didn't have the problems that model year 1 did.

To Sarah's point, the flexibility in bipartisanship in MACRA is a huge opportunity basically. And it's a huge opportunity to utilize the entire Medicare program as a driver of value versus self-containing, let's say, all of the potential and just in area like CMMI.

Going forward my hope is that we can all engage in a conversation over how to improve the law in ways that make it a more effective driver of value. I will stop there. Thank you very much and happy to answer questions.

MR. GINSBURG: Yeah. Thank you, Robert. I came into this panel with a couple of questions. And I think they have been answered pretty well by the panelists. So, let me not have them repeated. First I want to ask the panel if they -- the panelists if they have anything they would like to say inspired by what other panelists said and then I am going to go to the audience for -- which did not have a chance to ask questions after the first panel and I want to make sure that you do after this one. Any comments? Okay. Yeah, there is woman there with her hand up. Please introduce yourself.

MS. MCLAUGHLIN: Good morning. Can you hear me?

MR. GINSBURG: Yes.

MS. MCLAUGHLIN: My name is Jennifer McLaughlin with the Medical Group Management Association which represents practice administrators. And to build on comments made by Sarah, Robert, and Shari in the last panel, we have done a lot of work with the physician community, cardiology, AMA to coalesce around this idea around multi-category credit and I would especially be interested in your thoughts, Sarah, Jim, Robert as well -- some of the pushback we have gotten from officials in the administration has been that this would be the equivalent of double-dipping because the statute lays out four separate categories. You have to separately report within each of them.

But if for instance, CMS did want to incentivize reporting around really important issues like take the opioid epidemic and there were quality measures and improvement activities, potentially some cost lever -- that's less likely right now but absolutely a certain component. And they wanted to bundle that and allow group practices to report once on the activity that they are doing, say to consort to prescription management drug program within their state, report that information to the public health registry and document that through quality metrics, through improvement activities through use of CERT.

Our request to CMS was to recognize that as a comprehensive, sort of, bundle if you will within MIPS and don't require group practices to put in all of the burdensome requirements to separately meet those three different buckets but rather just allow them to say we are doing this important work, can we get credit across the MIPS program? The pushback again has been that could be perceived as double-dipping. What are your thoughts on that?

MR. HORNE: I will answer this somewhat amorphously but understanding I haven't seen all the details let's say of the proposal. Look I do think, again just to back to Shari's point, I don't want to put too many words in her mouth, so -- but there is a lot of flexibility in the law to think about those four categories not as separate categories but as areas, let's say, of measurement and activity that in some respects could be relied upon for the purposes of measurement.

And again, the re-weighting flexibilities that are in the law if you look closely at the language around the re-weighting, do allow for areas of condensing those four categories into smaller amounts of categories. It's largely wrapped around CPIA but, you know, the interpretive powers of the administration basically in the intent of Congress was always, we don't necessarily want to formulaically think about these four categories as simply four categories.

Now I will say this, I think, the administration and others are still feeling their way around what is a very complex but very dynamic law. And so, I think, from an organizational standpoint, opportunities to engage the administration and Congress in what the opportunity is but also maybe how to support it can be an effective strategy for exploring new ways.

MR. GINSBURG: Other questions. Yes. And then this next one is this gentleman back there afterwards.

MS. LEVIN: I would just add that, you know, I think the idea of MACRA in general was to streamline and to really -- and to think about different ways to make reporting

easier while also making it more useful and value based. And so, you know, I don't know the specifics of your proposal or CMS' challenges but even having different activities that you are doing within those four buckets, they could be all -- even if you are doing them within the four buckets, they could be aligned towards the same goal, which is really what the intention is supposed -- is to, you know, drive value whether it's in the opioids here in reducing those unnecessary prescriptions or others.

MR. GINSBURG: Yeah. Let's hear from Aaron Lyss.

MR. LYSS: Yeah. So, I think Matthew brought up a very critical issue that I think has been understated, you know, throughout the morning which is the importance of benchmark setting and target price setting in getting that right and having that be -- having those target prices and benchmarks be equitable. Though it's one element of it that I didn't hear that I think is a very significant concern. I was wondering how the, you know, panel would propose addressing this. But that is the -- I mean, the degree of innovation in therapies and in diagnostics that we have seen over the past several years is fundamentally different than a lot of the data on which these models were based. And I think that -- I would be interested in hearing your all's perspective on how to account that. To me, it just seems like that is -- it requires a degree of technical expertise in various specialties addressed by these APMs that's hard to -- you know, that's hard to get and hard to account for in the design of these models.

MR. FIEDLER: So, to share a couple of thoughts. But I think to some extent this just hard technical problem that we don't have perfect answers to. But I think there are two approaches -- broad approaches you can try to take. One is in terms of, you know, growth rates over time instead of is doing more, sort of, peer benchmarking of growth rates so in so far as everyone is being affected by the same technological changes that at least to some degree can capture those sorts of trends. Now I think the challenge is you got to really make sure that the peer groups you have for any given practice do have the same patient mix and are being affected by those technological changes in the right -- in the

appropriate -- in the same way. So, I think that's a challenge.

I think the other approach and I think this becomes a bigger problem on some of the narrower models are right if you have got a broader patient population that hopefully some of this averages out a little bit more where there may be more technological change in this area of care but as much in that one. It's one of the reasons that over the long run I tend to think that -- it's one of the advantages of total cost of care models over, sort of, episode focused models because I think they may be more robust to some of these challenges. But it's, I think, there is no perfect solution.

MR. GINSBURG: I think there is a gentleman back there.

MR. MCNEAL: Hi. David McNeal with the National Health Advisors. I appreciate Robert and Sarah's points about where we were with SGR and where we are going with MACRA. And in the physician groups that I work with are very appreciative of the change and what Congress did to pull us out of that morass of cost and SGR fixes. And I think that even though we appreciate what MIPS is trying to do, we do, sort of, look at it as, you know, value purgatory that we are, sort of, there as we wait for the advanced alternative payment models to come on line and we realized that's going to be a process. But by and large the physicians I talk with, they don't just want one APM. They want multiple APMs, they want multiple on-ramps.

And my question for those on-ramp, sort of, comes back to Dr. Fiedler, you made some comments about the mandatory nature of APMs. And I am, kind of, wondering where should those lines be drawn? Should it be that you are on the MIPS track and then there is one on-ramp to APMs and you make that one APM mandatory for that group or do you wait for multiple options to be ready and say, okay, this clinical space has enough options to -- for most of you to be in the APM track?

And I think we are seeing, sort of, play out with CJR being the first mandatory bundle. But also, with BPCI Advance coming online, for those physicians that are in CJR MSA but are actually being successful under the BPCI model, that they do not

have the option to continue on into the BPCIA model. They are actually being forced from a successful BPCI experience into CJR. And that's, sort of, another wrinkle to that mandatory aspect. And how do you see that playing out?

MR. FIEDLER: So, I think there are two broad philosophies here in terms of whether we want broad choice in APMs or whether we want to really focus around the small set of models. I tend to be on the -- focus around the small set of models. And there are three reasons for that.

One is, I worry about a proliferation of a lot of different models just being a very complex environment both for providers to navigate and for policy makers to manage. I think the second is, I think in many of those cases, I worry about balkanization where we have got narrow focused models that -- because different types of clinicians and different types of providers are very focused on the measures and financial performance in their particular models that we are inhibiting what, in many cases, is cross-provider type collaboration that we think we really want to foster.

And then the third challenge is a major just arbitrage concern that I think if we have got, you know, providers with a menu of, you know, three or four different models to choose from, inevitably, some of the financial terms of some of those models are going to be idiosyncratically more attractive to them than the others. They are going to choose those, and I think that may be very good for the providers involved but I think it can be very costly for the Medicare program.

And so, I think that tends to lead me towards a place of what we want is a fairly restricted menu of models that we can then find ways for a broad array of clinicians to find way and engage with and tend to.

MR. HORNE: I would like to may be speak to that as well. I have a slightly different take. It's not to disagree at all but -- look, I tend to think that more options are better. How you get to more options, I think, is a very important question. And there should be integrity in that. Would suggest right now that APMs largely, ACOs specifically, a cost

savings potential is largely undetermined at this point. I think the data supports that. I think we all see the potential and agree with the proposition that a new value proposition can save money.

I think one of the downsides of focusing on a small subset are that you limit your chances for success and actually defining what that savings is. I think in part two what I would love to see is maybe an initial focus on some areas where a small set are there but where the strategy is to identify components of those models that can't be replicated for the purposes of allowing a little bit more individualization down at the provider level both from a standpoint of specialty focus but also geographic location and ability.

Sub-specialty right now, they may never get to an APM the way we are going right now. So, in some respects we are almost creating a second class of citizen in the physician community or the system is focused on value and they have no ability on their own to drive it.

Number two, I would suggest is that if we focus on small subsets and we continue on that and we utilize CMMI as the only approach, we run the risk that by the time we identify a model seven to ten year down the line, it's already outdated. Component approach in some respects allows us to look a little bit farther in the future. And again, I think there are ways in which physician reporting can help on an iterative basis inform what next generation models look like ten and fifteen years down the future.

Largely, I will end with this. I think I agree with you that MIPS today can be improved upon. I really do. I would also suggest that providers that are waiting under the current system for their place on the APM pathway could be waiting for twenty or more years. And I don't necessarily know if that's a sustainable place either.

MR. GINSBURG: Yeah. Actually, as a final thought on this particular discussion. Seems as though the big choice in APMs is with an emphasized population models. And not only emphasize -- you know, versus episodic models, which I agree with Robert they, you know, they then have to be customized to lots of different specialties. But,

to me, that's the weakness of that approach. And the population approach could include -- and I put the word could include -- the flexibility for those like ACOs taking the population risk to actually innovate in the payment for particular episodes that are important to them and figure out how to do it their way, rather than doing it through the regulatory channels which take so much longer.

I was going to close the meeting, but you seem eager enough to say something.

AUDIENCE: Hi. I am fourth year resident physician at Georgetown and I did my MBA on value-based care. I work very close with my medical society which is the AAPM&R Medical Society. And one of the big issues that I think we really should expand upon are building registries and making that more points on the scorecard. Because I think if we have registries that can actually -- that are meaningful and have like more measures within the registry that can capture data for evidence, we can build episodes of care and, I think, build -- once we have that we can really build APMs. What are your thoughts about expanding upon registries for each specialty society?

MS. LEVIN: I would say that there are registry pathways built into the law as a recognition of the usefulness of the data that is inputted into the registries and also that there the societies have developed in and created as specific to the type of work that specific medical profession engages in. And so, I think that, you know, Congress found the value in them and included them as a result of that. So, there are obviously implementation questions that are being considered and changes that are even being considered in last week's new regulation that CMS put forth. But, you know, the use of the information that is put in there in -- can provide some information that -- some answers to some questions that I think that are useful that you discussed.

MR. HORNE: And actually, if I can just add a little bit too -- it's funny that registries, and Sarah knows this, it's probably the most often used word in the MACRA statute. I mean, it's everywhere. It became a joke among the Committees at one point

because everything was 'and registries'. But there was a reason for that too. And it was -- it's somewhat more of a maybe hope for ways that registries could be utilized. And so, I think, sort of, your question -- the question becomes how they are recognized, not so much just the recognition themselves.

But, you know, ultimately CMS has a computer and capability problem, in that CMS doesn't have the modern analytic capabilities that private businesses and organizations do. Somebody once told me that it has a 1980s computer system that's still basically on Apple IIe. It's not to denigrate CMS at all, it's not. But its ability to evaluate the value is limited.

Registries empowered with modern analytics could be one potential, let's say, to improve CMS' ability to opine on whether a value proposition works or not and recognizing registries as a conduit for gathering and submitting data to CMS might create shared opportunities for both the physician community and CMS to not only have the data but also understand what the data is telling us.

And again, I think, it comes down to how the recognition happens but if done in the right way it could be pretty powerful. Agree with you.

MR. FIEDLER: One thing I would add here is, just there is a strong -- registries have a strong public good aspect in that there is going -- you know, they enable a lot of types of research and learning that has systemic benefits that are potentially, you know, beyond the level of the individual clinician. And so, I do think, you know, even if you were in a world where, you know, where I got my wish and MIPS went away, I think, maintaining some incentive for registry reporting would have a strong rationale for it.

MR. MATTHEWS: If I can just weigh in --

MR. GINSBURG: Sure.

MR. MATTHEWS: -- very quickly on this point as well, speaking for the Commission staff, not the Commission as a whole just yet. We are contemplating the role of registries in overall, you know, physician value improvement activities. And some of the

things we would be concerned about, if these become a vehicle for again moving substantial amounts of Medicare dollars around would be, what kind of data validation efforts occur on the front end? How open are these things? How accessible is the data to, you know, the research community to policy makers? What activities do the owners or managers of the registries do to push that information out in some aggregated form to the people who submitted it in order to ensure that it is indeed being used for purposes of quality improvement, practice improvement as opposed to just sitting in the registry as a black box allowing a submitter to say yes, I participated in a registry?

So, we think there is probably some potential there, but we would want to see how that information is actually used to drive change before we would buy into this as again a vehicle for moving Medicare dollars around.

MR. GINSBURG: Thank you. One final thing on registries. I am a Public Trustee of the American Academy of Ophthalmology and it's been exciting as that academy as developed a very successful registry and it has gotten really advanced knowledge about what works and what doesn't work in Ophthalmology besides all the other things about giving feedback to physicians as to how they are doing.

I would like to thank this panel. They have done a marvelous job, as well as the earlier panel. I want to thank Lauren Adler and Abby Durac of the Center for Health Policy staff for planning this conference and supporting. And finally, to the Schaeffer Initiative -- USC-Brookings Schaeffer Initiative for Health Policy for providing the funds to pursue it. Thank you all very much.

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