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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

April 18, 2016

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

On **Tuesday, April 19th, at 10:15 a.m., in Room 2322 of the Rayburn House Office Building**, the Subcommittee on Health will hold a hearing titled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

I. BACKGROUND ON THE SUSTAINABLE GROWTH RATE

The Balanced Budget Act (BBA) of 1997 created the "sustainable growth rate" (SGR) formula. The SGR tied growth in Medicare physician payments to Gross Domestic Product (GDP) in an attempt to keep Medicare physician spending growth in line with the growth of the U.S. economy. At first, the economy was growing rapidly, and Medicare physician updates increased each year.

In 2001, Medicare spending exceeded the GDP-based growth target for the first time, and the SGR generated a reduction in physician payments for 2002 of negative 4.8 percent, which went into effect. Each year since, SGR calculations have led to reductions which Congress has acted to avert through SGR patches or "doc fixes." Because the SGR formula was designed to recoup unexpected spending, each patch increased the size and cost of the fix needed the next time. Before its repeal last year, the SGR would have resulted in a cut to physician payments of more than 20 percent. Since 2002, Congress has spent nearly $170 billion on short-term SGR fixes to prevent pending cuts.

II. MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

In early 2014, an agreement was reached between the Chairmen and Ranking Members of the House and Senate Committees of jurisdiction, which includes Energy and Commerce, Ways and Means and Finance. Together, they introduced a bipartisan bill to permanently repeal the SGR and replace it with a system that rewards value and quality (H.R. 4015, 113th Congress).

Seeing that it was unable to agree on whether and how to offset the SGR repeal bill (before the last patch expired), Congress postponed further consideration of the bill. Rather, Congress went on to enact another year-long patch, which maintained physician payment rates through March 31, 2015, at a cost of $15.8 billion.[1]

In March 2015, Congress then came to an agreement on offsetting the cost of the SGR repeal and replacement policy. H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) passed the House with overwhelming bipartisan support by a vote of 392-37**.** The Senate passed it shortly thereafter. On April 16, 2015, the President signed MACRA into law.

In addition to repealing and replacing the SGR, MACRA extended the Children's Health Insurance Program (CHIP) through FY2017, funding for community health centers through FY2017, and various Medicare policies. The bill also permanent extended on of the Qualifying Individual (QI) program, which helps low-income seniors pay their Medicare Part B premiums. The bill was partially offset with savings from Medicare and Medicaid. (See the attached summary for additional information)

A. MACRA Medicare Policy Overview

The intent behind MACRA was to not just repeal the flawed SGR formula, but to also fundamentally realign payment incentives in Medicare to reward value over volume.

Immediately following repeal of the SGR, MACRA went into effect to provide a five-year transitional period of 0.5 percent annual physician payment updates, until 2018. Beginning in 2018, financing will shift from being primarily a fee-for-service, volume-based payment system to one that focuses increasingly on quality, value and accountability. This is achieved by creating two paths for physicians: a value-based fee-for-service model, known as the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs).

B. Merit-based Incentive Payment System (MIPS)

MIPS is scheduled to commence in 2018. Physician payments will be adjusted according to their performance under MIPS, which streamlines three current quality performance incentive programs: Physician Quality Reporting System (PQRS), Value-based Modifier (VBM) and Meaningful Use. These programs and their respective incentives and penalties will sunset in

[1] Protecting Access to Medicare Act, PL 113-93.

2017, and will be replaced by the new MIPS. MIPS adjustments are capped at 4 percent in 2019, and shall gradually increase to a 9 percent cap in 2022.

MIPS will assess performance of eligible professionals in four categories: quality, resource use, electronic health records (EHR) meaningful use, and clinical practice improvement activities.

- **Quality.** Measures used for the Quality performance category will be published annually. In addition to the measures used in the existing quality performance programs, the Secretary would solicit recommended measures and fund professional organizations and others to develop additional measures. Measures used by qualified clinical data registries may also be used to assess performance under this category.
- **Resource Use.** The Resource Use category will include measures used in the current VBM program. The methodology that CMS is currently developing to identify resources associated with specific care episodes would be enhanced through public input and an additional process that directly engages professionals. This additional process allows professionals to report their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode). This additional process addresses concerns that algorithms and patient attribution rules fail to accurately link the cost of services to a professional. A resource use measurement would also reflect additional research and recommendations on how to improve risk adjustment methodologies to ensure that professionals are not penalized for serving sicker or more costly patients.
- **EHR Meaningful Use.** Current EHR Meaningful Use requirements, demonstrated by the use of a certified electronic system, will continue to apply in order to receive credit in this category. To prevent duplicative reporting, professionals who report quality measures through certified EHR systems for the MIPS quality category are deemed to meet the meaningful use clinical quality measure component.
- **Clinical Practice Improvement Activities.** Professionals will be assessed on their efforts to engage in Clinical Practice Improvement Activities. Incorporation of this new component gives credit to professionals who work to improve their practices and facilitate future participation in APMs. The menu of recognized activities will be established in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas.

Eligible professionals are not limited to doctors (MD or DO), but rather also include doctors of dental surgery or dental medicine, optometrists, chiropractors, physician assistants, nurse practitioners and others. The specific quality metrics used will be tailored to different provider specialties, and each eligible professional will receive a composite quality score ranging from 0-100. This score will be the basis of payment adjustments, with lower scoring providers receiving downward adjustments, and higher scoring providers receiving upward adjustments. Overall, incentive payments will be capped at an aggregate of $500 million annually.

C. Alternative Payment Models (APMs)

MACRA provided another route to incentivize the movement away from volume-based payments by giving financial bonuses to providers who participate in APMs. Beginning in 2018, qualifying APM participants, who receive a significant portion of their Medicare revenue from APMs, will receive a 5 percent bonus annually through 2024. After this, qualifying APM providers are eligible for a 0.75 percent annual increase in their Medicare payments. Qualifying APM providers are not subject to MIPS. If a provider does not meet the APM "significant portion" threshold (initially 25 percent of Medicare revenue), he or she would remain in MIPS. Starting in 2021, the threshold may be reached by combining revenue from APM arrangements in Medicare *and* other payers.

In order to make APMs available to the greatest number of professionals, MACRA encouraged the Secretary to test a variety of APMs, specifically APMs relevant to different specialties, small practices, and those that align with private insurer and state-based initiatives. Additionally, MACRA established the Physician-Focused Payment Model Technical Advisory Panel, which develops and recommends APMs to the Secretary.

D. Quality Measure Development

In order to both streamline and fill in current gaps in quality measures, the Secretary is required to create and publish a quality measure development plan (for use in both MIPS and APMs) with input from stakeholders by May 1, 2016. The plan should prioritize outcome measures, patient experience measures, care coordination measures, measures of appropriate use of services, and it should also consider gaps in quality measurement and applicability of measures across health care settings. For each year following 2016, the Secretary is required to report on the progress made in developing quality measures. From 2015 to 2019, $15 million is dedicated annually for this process.

III. WITNESSES

Dr. Jeffery W. Bailet MD, MSPH, FACS
Executive Vice President, Aurora Health Care
Co-President, Aurora Health Care Medical Group

Dr. Barbara L. McAneny MD
On behalf of the American Medical Association

Dr. Robert McLean MD
On behalf of the American College of Physicians

Dr. Robert Wergin MD, FAAFP
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