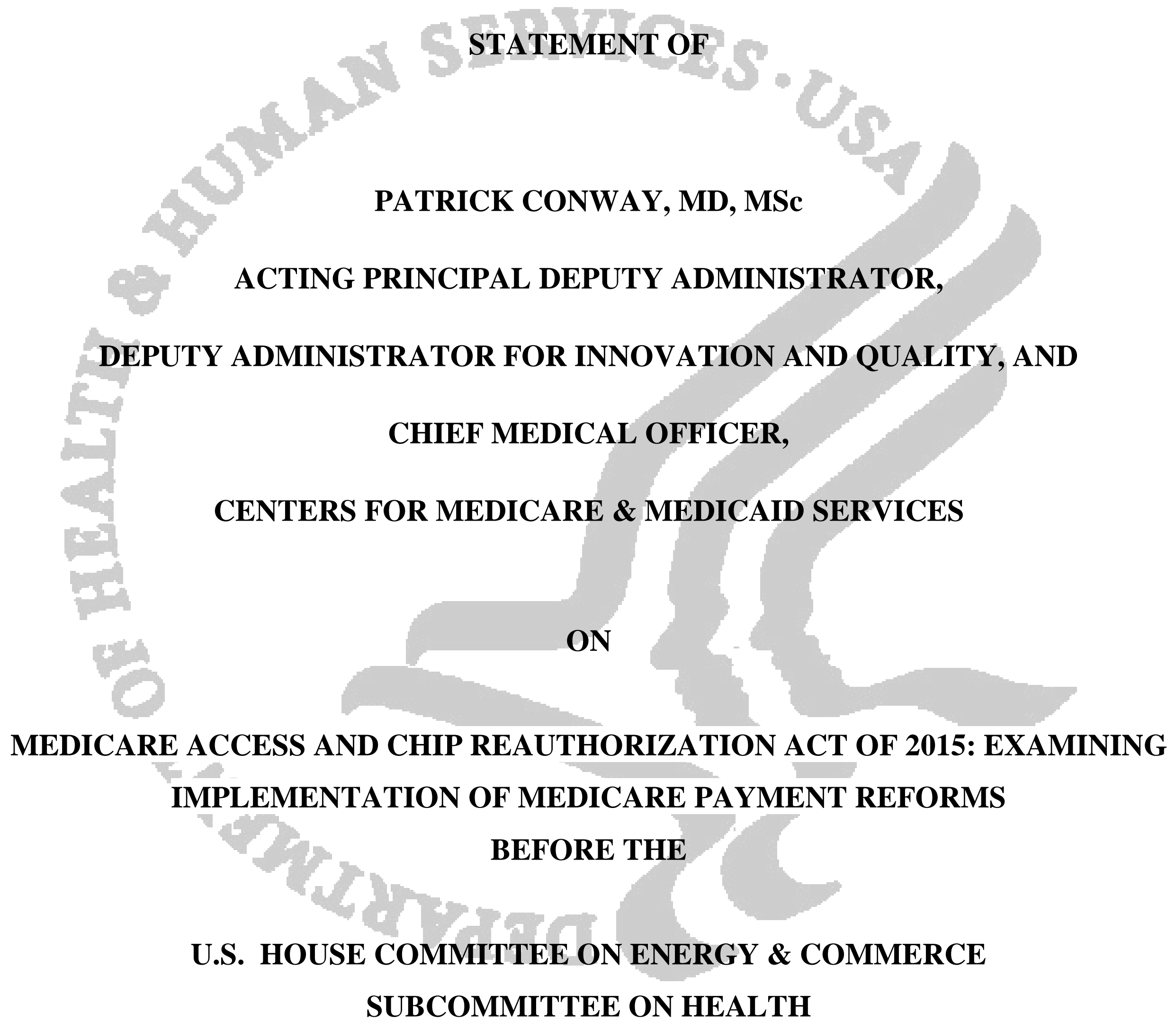

STATEMENT OF

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ON

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015: EXAMINING IMPLEMENTATION OF MEDICARE PAYMENT REFORMS

BEFORE THE

U.S. HOUSE COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON HEALTH

MARCH 17, 2016

U.S. House Committee on Energy & Commerce

Subcommittee on Health

"Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms"

March 17, 2016

Chairman Pitts, Ranking Member Green, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss the Centers for Medicare & Medicaid Services' (CMS's) work to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The law provides an opportunity for CMS to leverage performance measurement and new payment models as a key driver to further the Administration's commitment to building a better, smarter, healthier system that puts educated, empowered, and engaged consumers at the center of their care. It is our role and responsibility to help lead this change and to continue partnering with lawmakers, physicians, healthcare providers, consumers, and other stakeholders across the nation to make a transformed system a reality for all Americans.

Today, almost 60 million Americans are covered by Medicare — and 10,000 become eligible for Medicare every day. For many years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered, not the value of those services. In January 2015, the Administration announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. The Administration set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to alternative payment models (APMs) – such as Accountable Care Organizations (ACOs), advanced primary care medical homes, or bundled payment arrangements – by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. The Administration also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. These goals for APMs and value-based payments are the first in the history of the Medicare program.

Earlier this month, the Administration announced that it has already reached its first goal ahead of schedule: an estimated 30 percent of Medicare payments are tied to APMs as of January 2016, and millions of Medicare patients are benefitting from better coordinated and improved quality of care. [1] This milestone was met when 121 new ACOs joined the Medicare program on top of new participants in models such as the Bundled Payments for Care Improvement Initiative and Comprehensive Primary Care Initiative.[2] We expect these gains will continue to increase over the course of the year with the start of the Comprehensive Care for Joint Replacement model and the Oncology Care Model. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible.

While we are pleased with Medicare's progress, successfully transforming the health care system depends upon a critical mass of partners adopting new models. It is vital to engage partners who are also committed to, and have a stake in, improving our health care system, including patients, providers, payers, government, and businesses. This is why we helped launch the Health Care Payment Learning and Action Network (LAN) in March 2015 to bring together stakeholders in the public and private sector to accelerate adoption of value-based payments and APMs. More than 4,800 patients, insurers, providers, states, consumer groups, employers, and other partners joined the LAN and over 50 organizations have made commitments to payment transformation, including health plans, provider organizations, consumer groups, and state governments. The LAN is working to identify areas of agreement around movement to APMs and is collaborating to generate evidence, share best practices, and remove barriers to success. Just one example of the LAN's work is the development of a detailed framework for APMs, which can be used to describe and measure progress in the adoption of APMs across the U.S. health care system. This framework was released in January 2016 and is only the first step of the LAN's efforts, which are now focused on patient attribution, financial benchmarking, and clinical episodes, among other topics.[3] This example shows that CMS, working with a multitude of partners through the LAN, can help the health care system meet or exceed the Medicare goals for value-based payments and APMs.

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[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03.html
[2] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html
[3] https://hcp-lan.org/workproducts/apm-whitepaper.pdf

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

We thank Congress for their leadership in passing the bipartisan MACRA, which was signed into law on April 16, 2015. The passage of MACRA supports the ongoing transformation of health care delivery by furthering the development of new Medicare payment and delivery models for physicians and other clinicians. The law repeals the sustainable growth rate formula for updating Medicare physician fee schedule (PFS) payment rates and substitutes a series of specified annual update percentages. It also establishes a new methodology that ties annual PFS payment adjustments to value through a Merit-Based Incentive Payment System (MIPS) for certain eligible professionals (EPs) and creates an incentive program to encourage participation by EPs in certain APMs.

CMS is committed to engaging with stakeholders in implementing this important legislation. In CMS's calendar year 2016 PFS proposed rule, we solicited comments regarding implementation of certain aspects of the MIPS and broadly sought comments on the topics in MACRA, including the framework for providing the incentive payments associated with APM participation. On October 1, 2015, we released a Request for Information (RFI), asking for comments from the stakeholder community on many topics related to MIPS, APMs, quality measurement, and meaningful use of certified electronic health records (EHRs). Further, in December 2015, CMS, in conjunction with the Office of the National Coordinator for Health Information Technology, issued an RFI to assess policy options that could improve the effectiveness of the certification of health information technology and specifically the certification and testing of EHR products used for the reporting of quality measures. We know physicians and other clinicians have a lot of demands on their time, and we are grateful for the robust response from the stakeholder community to these requests for feedback. We are currently in the process of reviewing and incorporating the feedback we received, and we anticipate releasing a proposed MACRA implementation rule, including a 60-day comment period, this spring. We look forward to continued engagement from Congress and the health care community.

Quality Measurement Programs and the Merit-based Incentive Payment System (MIPS)
The provision of quality health care for Medicare beneficiaries is a high priority. Prior to MACRA, Congress established three programs to link payment with quality and value for physicians and other clinicians. Under the Physician Quality Reporting System (PQRS), EPs submit data on quality measures to avoid a payment adjustment. The program originally provided an incentive payment to participants who satisfactorily reported. Beginning in 2015, incentives were replaced with negative payment adjustments for individuals and group practices that do not satisfactorily report data on quality measures or satisfactorily participate in qualified clinical data registries. The Physician Value-based Payment Modifier (VM) applies a payment adjustment based on participants' performance on quality and cost metrics. The VM applied to large group practices in 2015, smaller groups in 2016, and will apply to individual physician EPs and groups in 2017. The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage participants to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology. These programs provide incentive payments to participants meaningfully use certified EHR technology, and as of 2015, participants that do not meet the requirements of the Medicare EHR Incentive Program and that do not qualify for a hardship exception receive a negative payment adjustment.

The PQRS, VM, and EHR Incentive Program have each played an important role in the development of physician-based quality measurement and reporting in the Medicare program. MACRA changes and combines these programs for applicable Medicare eligible professionals and accelerates the alignment of measures, program policies, and operations by sunsetting their separate payment adjustments under the PQRS, VM, and EHR Incentive Program at the end of 2018 and establishing the MIPS in their place beginning with payments in 2019. The MIPS is a rigorous value-based purchasing program for physician services. EPs will be scored under MIPS based on a single composite performance score, which will factor in performance in four weighted categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology.

We are working hard to establish the proposed measures and activities that will fall under each of the four MIPS categories and appreciate the feedback we have received from stakeholders to the RFI, particularly regarding areas that are new to CMS, such as clinical practice improvement

activities. We are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare EHR Incentive Program for EPs as we transition it to MIPS. This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

Payment adjustments under MIPS are scheduled to begin in January 2019. Professionals will receive either a positive, negative, or neutral payment adjustment depending on their performance relative to a pre-established performance threshold. The downward adjustments are generally limited to 4 percent of the physician fee schedule amount in 2019, increasing to 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and subsequent years. While the upward adjustments can go above these percentages, the law generally requires the overall adjustments to be budget neutral, so the actual upward adjustments will be scaled in such a way to achieve this budget neutrality. MIPS is designed to give EPs a strong incentive to perform

well and the opportunity to improve their performance over time. In addition, in the first 6 years, Congress made available $500 million per year for additional positive payment adjustments for EPs with exceptional performance above a higher threshold amount.

While a large majority of Medicare EPs will be required to participate in the MIPS program, Congress established exceptions for EPs in certain situations, including: qualifying participants in certain eligible APMs, who will instead receive the APM incentive payment; professionals in their first year of Medicare participation; partial qualifying participants in certain eligible APMs; and professionals who do not exceed an established low-volume threshold. In addition, MIPS does not apply to hospitals or facilities.

Alternative Payment Models (APMs)

Over the past several years, CMS, through the Center for Medicare and Medicaid Innovation ("the Innovation Center"), has begun implementing many different payment models to test ways to improve the quality and value of care provided to beneficiaries in the Medicare program. Generally speaking, an APM is a model that holds providers accountable for the quality and cost of the care they deliver to a population of patients by providing a financial incentive to coordinate care for their patients. This helps ensure patients receive the appropriate care for their conditions and reduces avoidable hospitalizations, emergency department visits, adverse medication interactions, and other problems caused by inappropriate care or siloed care.

MACRA established a particular definition of APMs and established what qualifies as an "eligible APM," for purposes of exempting EPs from MIPS and allowing EPs to receive a special incentive payment as a qualifying APM participant. The statute establishes key criteria for these eligible APMs, including that they must require the use of certified EHR technology, base payment on quality measures comparable to those in MIPS, and either place participants at more than nominal financial risk or be a medical home that has been expanded under Innovation Center authority. (Or, in the case of a Medicaid medical home, is a medical home that that meets criteria comparable to medical homes expanded under Innovation Center authority.) EPs who participate in these eligible APMs and meet specified annual payment or patient count thresholds established in the statute are eligible to earn a 5 percent incentive payment for each of the years they meet those thresholds from 2019 to 2024. In this way, MACRA provides incentives to those

physicians and other clinicians committed to operating in very advanced APMs, including those with more than nominal financial risk.

While creating this new category of eligible APMs provides for promising incentives for a growing number of EPs in the future, we expect the initial years to be ones of development as we apply lessons learned and continue to refine the program. As discussed above, the statute creates a high bar for eligible APMs. Many currently existing APMs – at the Innovation Center and in the private sector – are not likely to meet all these requirements, but some will. We will continuously search for opportunities to expand the range of options for participation in eligible APMs within the contours of the statute. In keeping with the statute, it is our intent to align the MIPS and APM components of the new payment system to the extent feasible, thus allowing maximum flexibility for physicians and other clinicians who are not yet ready for eligible APMs to participate in MIPS and then migrate to eligible APMs when they are ready. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs.

Physician-Focused Payment Model Technical Advisory Committee

In addition to establishing MIPS and creating new incentives for participation in eligible APMs, Congress established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC meets on a periodic basis to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The first PTAC meeting was held on February 1, 2016, and presentations from the meeting are available online.[4] CMS looks forward to receiving recommendations for new physician-focused payment models. We will need stakeholder engagement with the PTAC, including physicians and other clinicians, to suggest well designed, robust models that could meet the statutory criteria to be an eligible APM.

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

Technical Assistance

We know that physicians and other clinicians may need assistance in transition to the MIPS and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an APM. . We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

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

Conclusion

MACRA will help move Medicare towards rewarding the value and quality of physician services, not just the quantity of such services. As a practicing physician who has also led quality improvement efforts in health systems, I know the importance of quality measurement and improvement. We intend to use a patient-centered approach that leads to better care, smarter spending, improved patient outcomes, and program development that is meaningful, understandable, and flexible for participating clinicians. It is our role and responsibility to continue leading this change and to continue partnering with lawmakers, physicians, and other providers, consumers, and other stakeholders across the nation to make a transformed system a

reality for all Americans. We look forward to working with this Committee, members of Congress, and other stakeholders as we continue to implement this seminal piece of legislation.