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ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515-6115

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MEMORANDUM

November 6, 2017

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "MACRA and Alternative Payment Models: Developing Options for Value-Based Care"

On **Wednesday, November 8, 2017, at 10:00 a.m., in room 2123 of the Rayburn House Office Building**, the Subcommittee on Health will hold a hearing titled "MACRA and Alternative Payment Models: Developing Options for Value-Based Care."

I. THE SUSTAINABLE GROWTH RATE (SGR) AND THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

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. 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. Each year thereafter, SGR calculations led to a reduction in physician payments, which were patched annually. Because the SGR formula was designed to recoup unexpected spending, each patch increased the size and cost of the fix needed the subsequent time. In its final year, the SGR would have resulted in a cut to physician payments of more than 20 percent.

In early 2014, the Chairmen and Ranking Members of the House Energy and Commerce and Ways and Means Committees, and the Senate Finance Committee introduced a bipartisan bill to permanently repeal the SGR and replace it with a system that rewards value and quality.[1] Congress was not able to reach an agreement on how to offset the SGR repeal bill before the last patch expired, an

[1] H.R. 4015, SGR Repeal and Medicare Provider Payment Modernization Act of 2014, 113th Congress.

additional year-long patch was enacted to maintain physician payment rates through March 31, 2015, at a cost of $15.8 billion.[2]

In March 2015, Congress 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, MACRA was signed into law.[3]

II. MACRA 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. MACRA offers two paths for physicians to make the shift from a fee-for-service, volume-based payment system to a value-based payment system that focuses increasingly on quality, value and accountability: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

A. The Merit-Based Incentive Payment System (MIPS)

MIPS is scheduled to commence in 2018. MIPS streamlines three current quality performance incentive programs under Medicare: Physician Quality Reporting System (PQRS), Value-based Modifier (VBM) and Meaningful Use, and adjusts physician payments according to their performance under these measures. The three separate programs and their respective incentives and penalties will sunset in 2017, and will be replaced by MIPS.

MIPS will assess the performance of eligible professionals in four categories: quality, resource use, electronic health records (EHR) meaningful use, and clinical practice improvement activities. MIPS adjustments (positive or negative) are capped at four percent in 2019, and will gradually increase to nine percent in 2022. Physicians at or above the performance threshold (the mean or median performance of all MIPS-eligible professionals) will be eligible for an increased payment, while individuals below the threshold will receive a cut to their payment. MIPS offers additional positive adjustments for exceptional performance, capped at an aggregate of $500 million annually from 2019 through 2024.

B. Advanced 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 Advanced APMs. Generally speaking, an APM is a payment approach that provides incentives for clinicians to provide high-quality, cost-effective care for a specific clinical condition, population, or episode of care. MACRA created Advanced APMs which go a step further and has physicians accept some financial risk for the healthcare quality and cost outcomes of their patients (i.e. they are "on the hook" if actual expenditures exceed expected expenditures), in exchange for greater rewards.

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

[3] Medicare Access and CHIP Reauthorization Act of 2015, PL 114-10.

An Advanced APM must meet the following three criteria under MACRA: 1) require participants to use certified EHR technology; 2) provide payment for covered professional services based on quality measures comparable to those used in MIPS; and 3) require participating APM Entities to bear more than a "nominal" amount of financial risk for monetary losses. CMS has defined "nominal" risk to mean that at least eight percent of the average estimated total Medicare Part A and B expenditures for the Advanced APM is at risk, or three percent of expected costs for which an APM is responsible is at risk.[4]

Beginning in 2018, qualifying APM participants, who receive a significant portion of their Medicare revenue from APMs, will receive a five percent bonus annually through 2024. A "significant portion" is considered initially 25 percent of Medicare revenue, or 20 percent of Medicare patients. 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 "significant portion" threshold 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.

C. Existing APMs

Since its inception in 2010, the Centers for Medicare and Medicaid Services Innovation Center (CMMI) has developed and tested a number of APMs, many of which now qualify as Advanced APMs under MACRA. These include certain accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and the Comprehensive Primary Care Plus (CPC+) model, as well as episode-based payments for treatment of specific conditions, such as the Comprehensive End-Stage Renal Disease (ESRD) care (CEC) model, Comprehensive Care for Joint Replacement (CJR) model, and the Oncology Care Model.

Medicare ACOs are voluntary networks of doctors, hospitals, and other suppliers who have come together voluntarily to share financial and medical responsibility for Medicare fee-for-service patients. As part of the program, ACOs enter into a three-year contract with Medicare. Each ACO is accountable for the total cost of care for their assigned beneficiaries, even if the care is provided outside of the ACO. If an ACO is successful in reducing costs and improving the quality of care, it is eligible for a portion of the savings it generates for Medicare. Currently, nine million Medicare beneficiaries are covered by 480 Shared Savings Program ACOs.[5] ACO models that qualify as Advanced APMs include the Next Generation ACO Model, Medicare Shared Savings Track 2, and Medicare Shared Savings Track 3 models.[6] These models offer financial arrangements with higher level of risk and reward than earlier Medicare ACO initiatives.

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[4] Centers for Medicare & Medicaid Services, *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models: Final Rule* (Nov. 4, 2016).

[5] Center for Medicare & Medicaid Services, *Fast Facts: All Medicare Shared Savings Program Accountable Care Organizations* (Jan. 2017).

[6] Centers for Medicare & Medicaid Services, *APMs Overview*.

The CPC+ model is designed to support and transform the delivery of primary care. The model consists of a per-beneficiary-per-month payment to participating primary care practices, and performance-based incentives based on how well the practice performs on patient experience, clinical quality, and utilization measures. CMS launched Round 1 of the CPC+ model in January of 2017 in 14 regions and across 2,850 primary care practices, serving 1.76 million Medicare beneficiaries.[7]

CMMI has also launched a number of condition specific or disease specific payment models that now qualify as Advanced APMs. For example, the ESRD model is a condition-based APM that focuses on improving the quality and efficiency of care for Medicare beneficiaries who require dialysis. Dialysis facilities, nephrologists (kidney specialists), primary care physicians and others form organizations and assume the full financial and clinical accountability for the assigned beneficiaries.

D. Physician-Focused Advanced APMs

MACRA created incentives for physicians to develop and participate in their own APMs, or physician-focused payment models (PFPMs). Section 101(e)(1) of MACRA established the Physician-Focused Payment Model Technical Advisory Panel (PTAC), to review and provide comments on PFPMs from stakeholders and individuals, and then make recommendations to the Secretary on the proposed models. The PTAC began accepting proposals for PFPMs beginning on December 1, 2016. It has begun the process of reviewing 19 submitted proposals, and has recommended two for testing by the Secretary. One of the models it has recommended for testing is the ACS-Brandeis Advanced APM submitted by the American College of Surgeons.

PTAC is composed of eleven members with national recognition in their fields of expertise. These members include both physicians and non-physicians and are appointed by the Comptroller General of the United States and remain in service for three-year terms.

III. WITNESSES

Panel 1:

Jeffrey Bailet, MD
Chairperson
Physician-Focused Payment Model Technical Advisory Committee

Elizabeth Mitchell
Vice Chairperson
Physician-Focused Payment Model Technical Advisory Committee

[7] Centers for Medicare & Medicaid Services, *Comprehensive Primary Care Plus* (https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus).

Panel 2:

Frank Opelka, MD
Medical Director, Quality and Health Policy
American College of Surgeons

Bill Wulf, MD
CEO
Central Ohio Primary Care Physicians
CAPG

Colin Edgerton, MD
American College of Rheumatology

Brian Kavanagh, MD, MPH, FASTRO
Professor and Chair
Department of Radiation Oncology, University of Colorado School of Medicine
President
American Society for Radiation Oncology (ASTRO)

Daniel Varga, MD
Chief Clinical Officer
Texas Health Resources
Premier, Inc.

Louis Friedman, MD
American College of Physicians