U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

April 15, 2016

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms"

I. INTRODUCTION

On Tuesday April 19, 2016, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

II. WITNESSES

Panel One:

- Robert McLean, M.D., FACP, Member of the Board of Regents, Chair of the Medical Practice and Quality Committee, American College of Physicians;
- Robert L. Wergin, M.D., FAAFP, Board Chair, American Academy of Family Physicians;
- Barbara L. McAneny, M.D, Immediate Past Chair, American Medical Association; and
- Jeffery W. Bailet, M.D., MSPH, FACS, Executive Vice President of the Aurora Health Care, Co-President of the Aurora Health Care Medical Group.

III. BACKGROUND

General Overview

The "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA), was the bipartisan product of years of work to repeal the Sustainable Growth Rate (SGR). In the 113th Congress, the Committee on Energy and Commerce, the Committee on Ways and Means, and the Senate Committee on Finance each reported bills to repeal the SGR and reform Medicare provider payments in order to streamline reporting, stabilize payments, focus on value, and encourage alternative payment models (APMs).[1]

[1] The full Committee on Energy and Commerce reported out H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013 by a vote of 51-0.

MACRA passed the U.S. House of Representatives on March 26, 2015, by a vote of 392-37 and passed the Senate on April 14, 2015, by a vote of 92-8. The President signed MACRA into law on April 16, 2015 (P.L. 114-10). This bipartisan legislation permanently repealed the SGR formula and provided stability in Medicare base payments for the following four and a half years. It streamlined Medicare's multiple quality reporting systems by sunsetting them and their associated penalty structures and reconstituting them into a single quality reporting system that seeks to make it easier for providers to report on and deliver high quality, value based care.

MACRA alters how the Medicare program pays for services, as well as how providers interact with the program. MACRA was designed with very specific goals that responded to years of criticism by stakeholders in how providers are reimbursed, how they interact with the program, the development of new quality measures and means of evaluating and integrating new practice models into the system. At the same time, MACRA was meant to bring much needed transparency into the development and operation of how the Medicare program reimburses providers.

The focus of the hearing will be on the efforts major physician organizations have and are undertaking to prepare for the practice reforms needed to successfully navigate the implementation of the Medicare payment reforms under MACRA. Many organizations for years prior to MACRA's passage have invested substantially in APMs, quality measures, and practice improvements that could serve as clinical practice improvement activities. Members will be able to hear about these investments and what resources providers have at their disposal to lay a foundation for success under Medicare's future payment system. Members will also be able to hear from these organizations about how they have been working with the Centers for Medicare and Medicaid Services (CMS) on the repeal of the SGR, the temporary payment stabilization under the fee schedule, the creation of the Merit-Based Incentive Payment System (MIPS), and the work that they are undertaking to encourage value based payments that would qualify as an eligible APM.

Permanent SGR repeal

MACRA permanently repealed the SGR formula that Congress consistently legislated to override. These last minute legislative actions caused disruption to the Medicare system, including to both patients and providers. At enactment, MACRA avoided a 21.2 percent cut that was scheduled to go into effect. It removed the yearly uncertainly surrounding the SGR and how Congress would mitigate cuts that threatened the viability of providers participating in the Medicare program, and in turn, the beneficiaries accessing the health care services they need. The law also provides for updates to the fee schedule of 0.5 percent from July 2015 through 2019. After that point, services on the physician fee schedule would remain at the 2019 level and be adjusted based on a provider's participation in MIPS or a qualifying APM. After 2026, providers will receive a 0.75 percent update for those participating in a qualified APM and .25 percent for all others.

The "Merit-based Incentive Payment System" (MIPS) quality program

In 2019, quality incentive programs, including the Physician Quality Reporting System (PQRS), Meaningful Use (MU), and the value-based payment modifier (VBM), will be combined and streamlined into a single new value based payment system. This process will utilize tools eligible professionals are already familiar with, such as certified EHR technology and qualified clinical data registries. The penalties associated with these previous programs will end in 2018, and the money that would have been assessed from these programs and their various penalty structures will remain in the fee schedule. MIPS will become the sole quality reporting system for eligible professionals who will see their reimbursement adjusted based on four categories: quality (30 percent), resource use (30 percent), MU (25 percent), and clinical practice improvement activities (15 percent).

MACRA makes several important changes to how CMS will interact with eligible professionals in these categories. For example, by building in the ability of the eligible professional to report their specific role in the treatment, the type of treatment, and means to improve risk adjustment, MACRA will help better educate eligible professionals on resource use. The law also requires the Secretary to publish quality measures yearly through notice and comment rulemaking. Instead of applying a one size fits all approach, MACRA allows eligible professionals and organizations to identify quality measures and then to tailor the quality measures that best fit their practice and specialty.

Each eligible professional reporting to MIPS will be given a composite score base on their performance in these categories on a scale of 0-100. Eligible professionals are assessed only on the categories that are applicable to them, and the categories may be reweighted to compensate as needed. Each year, the Secretary will establish a performance threshold based on the performance of all participating eligible professionals during a set period preceding the performance period. Eligible professionals will be informed of how they performed in the prior period and the performance threshold they must meet to be eligible for incentive payments and to avoid penalties. Those who score above the performance threshold are eligible for bonus payments; those below will receive negative adjustments relative to their score and the performance threshold.[2] This sliding scale approach abandons the all or nothing approach that many providers have criticized in current reporting systems. In addition, eligible professionals whose scores fall into a high performance category will receive an additional bonus payment.[3] Providers who make notable gains in performance also will be financially rewarded.

Alternative Payment Models

MACRA encourages providers to move away from traditional fee-for-service reimbursement by creating incentives to participate in new care delivery models that increase quality and reduce costs. MACRA recognizes the trend that has been growing outside of the traditional Medicare program that providers have sought new care delivery systems that better fit their practice's needs. On March 3, 2016, the Department of Health and Human Services

[2] Payment adjustments for 2019 will be 4 percent, for 2020, 5 percent, for 2021, 7 percent; and for 2022 and subsequent years, 9 percent.

[3] The additional payment is set at $500 million per year (or a maximum of 10 percent for an eligible professional) and is defined in statute as being set at either the 25 percentile of the range between he performance score and 100 or the 25th percentile of the scores above the performance threshold for 2019-2024.

announced that an estimated 30 percent of Medicare payments were tied to alternative delivery payments including:[4]

- Medicare Shared Savings Program (MSSP);
- Pioneer ACOs;
- Next Generation ACOs;
- Comprehensive End Stage Renal Disease (ESRD) Care Model;
- Comprehensive Primary Care Model;
- Multi-Payer Advanced Primary Care Practice;
- End Stage Renal Disease Prospective Payment System;
- Maryland All-Payer Model;
- Medicare Care Choices Model; and
- Bundled Payment Care Improvement.

MACRA builds off this work and provides 5 percent bonus payments from 2019 to 2024 for providers in an eligible APM. The statute defines APMs and eligible Alternative Payment Entities as follows:

Alternative Payment Models include:

- A model under section 1115A (other than a health care innovation award);
- The shared savings program under section 1899;
- A demonstration under section 1866C; or
- A demonstration required by Federal law.

Eligible Alternative Payment Entity participates in an alternative payment model that:

- Requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and
- Provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and either
- Bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or
- Is a medical home expanded under section 1115A(c).

Eligible APMs are required to bear financial risk in excess of a nominal amount, require participants to use certified EHR technology, and maintain a quality measurement component. Qualified Patient Center Medical Homes are exempt from the downside risk requirement. To encourage provider participation in eligible APMs, MACRA provides for a 5 percent bonus payment for professionals who receive a significant share of their revenues (both Medicare revenues and all payer APM revenue) through one or more APMs. These providers are exempt from MIPS reporting and assessment, as well as most meaningful use requirements.

[4] Available online at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html

MACRA also created a physician Technical Advisory Committee (TAC) to evaluate physician-focused APM proposals. CMS is required to provide a detailed response to any physician led TAC endorsed APM proposal.

STAFF CONTACTS

If you have any questions regarding this hearing, please contact James "J.P." Paluskiewicz with the Committee staff at (202) 225-2927.