



November 6, 2017

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing entitled “MACRA and Alternative Payment Models: Developing Options for Value-based Care”

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## I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Wednesday, November 8, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building. The hearing is entitled “MACRA and Alternative Payment Models: Developing Options for Value-based Care.”

The focus of the hearing will be on the implementation of one of the two tracks eligible professionals can be reimbursed under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), specifically Alternative Payment Models (APMs). The Committee will hear about these Medicare payment reforms, including models that are already under way, physicians are participating in, and which are returning savings to the program while improving outcomes. Members will also hear about the work of the Centers for Medicare and Medicaid Services (CMS) to encourage value based payments that would qualify as an eligible APM. Finally, the Subcommittee will hear from the Physician Technical Advisory Committee (P-TAC) and witnesses actively developing models that could be considered Advanced APMs in the future.

## II. WITNESS

### Panel One:

- Jeffrey Bailet, MD, Chairperson, Physician-Focused Payment Model Technical Advisory Committee; and
- Elizabeth Mitchell, Vice Chairperson, Physician-Focused Payment Model Technical Advisory Committee.

### Panel Two:

- 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;

- Daniel Varga, MD, Chief Clinical Officer, Texas Health Resources, Premier, Inc.;
- Brian Kavanagh, MD, Chair, American Society for Radiation Oncology (ASTRO); and
- Louis Friedman, DO, American College of Physicians.

### **III. BACKGROUND**

#### **General Overview**

The Medicare Access and CHIP Reauthorization Act of 2015, 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).<sup>1</sup>

MACRA passed the U.S. House of Representatives on March 26, 2015, by a vote of 392-37 and 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. The new system makes 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 to reform the Medicare program 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 is meant to bring much needed transparency into the development and operation of how the Medicare program reimburses providers.

#### **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 that this trend had and continues to grow among payors outside of the traditional Medicare program. This has led providers over the last few years to seek new care delivery systems that better fit their practice's needs while delivering better patient outcomes and allowing providers to share in savings. On March 3, 2016, the Department of Health and Human Services (HHS) announced that an estimated 30 percent of Medicare

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<sup>1</sup> 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

payments were tied to alternative delivery payments, and on pace to reach the previous administrations' 2018 target of 50 percent.<sup>2</sup> These alternative delivery payments included:

- 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, and
  - 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 eligible 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 fee for service reporting and assessment, as well as

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<sup>2</sup> Available online at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html>

most meaningful use requirements. For 2017, eligible APMs that meet CMS criteria for advanced APMs include:<sup>3</sup>

- Comprehensive ESRD Care (CEC) Model (LDO arrangement and non-LDO arrangement),
- Comprehensive Primary Care Plus (CPC+) Model,
- Medicare Shared Savings Program Accountable Care Organizations — Track 2,
- Medicare Shared Savings Program Accountable Care Organizations — Track 3,
- Next Generation ACO Model,
- Oncology Care Model (OCM) (Two-sided Risk Arrangement), and
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT).<sup>4</sup>

For performance year 2018, additional advanced APMs will include:<sup>5</sup>

- Medicare Accountable Care Organization (ACO) Track 1+ Model, and
- Surgical Hip/Femur Fracture Treatment (SHFFT) Model (Track 1 – CEHRT).

Additionally, the following Advanced APMs have reopened and have accepted applications for 2018 participation:

- Next Generation ACO Model, and
- Comprehensive Primary Care Plus (CPC+) Model.

A full list of APMs in the Quality Payment Program can be found at [https://qpp.cms.gov/docs/QPP\\_Advanced\\_APMs\\_in\\_2017.pdf](https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf).

Per CMS, the following models are considered Advanced APMs for 2017:

- **Accountable Care Organizations (ACOs)** are groups that may contain doctors, hospitals, and other health care providers who coordinate care of Medicare patients, often those suffering from chronic diseases. The model seeks to maximize coordination of care to reduce health care expenditures associated with duplication of services and better care alignment. Successful ACOs share in the savings that they provide for the Medicare Program. Of the ACO programs currently active and overseen by CMS, the following are currently considered Advanced APMs:<sup>6</sup>
  - **Medicare Shared Savings Program (MSSP):** The ACO is accountable for the care of an assigned Medicare fee-for-service (FFS) beneficiary population. The Shared Savings Program offers flexibility in participation options allowing ACOs

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<sup>3</sup> Available online at <https://qpp.cms.gov/apms/overview>

<sup>4</sup> The CJR Payment Model was withdrawn on 11/2/2017

<sup>5</sup> Available online at <https://www.federalregister.gov/d/2017-13010/p-124>

<sup>6</sup> Available online at <https://innovation.cms.gov/initiatives/ACO/>

to assume different levels of risk. Currently **Track 2** and **Track 3** MSSPs qualify as Advanced APMs.

- **Track 2 (Two-Sided Risk)** – “Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.”<sup>7</sup>
  - **Track 3 (Two-Sided Risk)** – “Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk, but may share in the greatest portion of savings if successful.”<sup>8</sup>
- **Next Generation ACO Model** – The Next Generation ACO Model is designed for ACOs with experience coordinating care for populations of patients, allowing them to assume higher levels of financial risk and reward than available under MSSP. This model tests a combination of strong financial incentives with tools designed to improve patient engagement and care management to determine if health outcomes can be improved and expenditures for Original Medicare FFS beneficiaries can be reduced. The model will be evaluated on improving delivery of care for individuals, improving health of populations, and decreasing growth in health expenditures. This model is accepting new applications for 2018 participation.<sup>9</sup>
  - **Comprehensive ESRD Care (CEC) Model** – The Comprehensive ESRD Model is designed to coordinate care amongst dialysis clinics, nephrologists, and other health providers treating Medicare beneficiaries with End-Stage Renal Disease. These ACOs, termed ESRD Seamless Care Organizations (ESCO), “are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries’ health needs, both in and outside of the dialysis clinic.”<sup>10</sup> The Model is separated into Large Dialysis Organizations (LDOs), with more than 200 dialysis facilities, and non-LDOs, with less than 200 dialysis facilities or hospital-based facilities. LDOs are both eligible to receive shared savings payments and liable for shared losses, while non-LDOs may participate in a one-sided track where they will be eligible for shared savings but not liable for payment of shared losses.
  - **Comprehensive Primary Care Plus (CPC+)** – “CPC+ is an advanced primary care medical home model designed to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.” There are

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<sup>7</sup> Available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html>

<sup>8</sup> Available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html>

<sup>9</sup> Available online at <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/index.html>

<sup>10</sup> Available online at <https://innovation.cms.gov/initiatives/comprehensive-ESRD-care/index.html>

2,850 primary care practices comprising 13,090 clinicians and serving more than 1.76 million Medicare beneficiaries participating in CPC+ Round 1. Starting on January 1, 2018, CPC+ Round 2 will support 1,000 additional practices statewide in Louisiana, Nebraska, North Dakota, as well as in the Greater Buffalo Region of New York. Participating practices are supported by 54 aligned payers in 14 regions in Round 1, and seven payers in four regions in Round 2. Aligning regional payers provides additional financial resources and investment flexibility to participating practices. Additionally, CPC+ provides practices with learning system infrastructure and data feedback to aid health care professionals in decision making to ultimately improve delivery of care.<sup>11</sup> CPC+ includes three payment elements:

- **Care Management Fee (CMF):** Both tracks provide a non-visit-based CMF paid per-beneficiary-per month (PBPM). The amount is risk-adjusted for each practice to account for the intensity of care management services required for the practice’s specific population. The Medicare fee-for-service (FFS) CMFs will be paid to the practice on a quarterly basis.
- **Performance-Based Incentive Payment:** CPC+ will prospectively pay and retrospectively reconcile a performance-based incentive based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care.
- **Payment under the Medicare Physician Fee Schedule:** Track 1 continues to bill and receive payment from Medicare FFS. Track 2 practices also continue to bill FFS, but the FFS payment will be reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which will be paid in a lump sum on a quarterly basis absent a claim.” According to CMS, “given our expectations that Track 2 practices will increase the comprehensiveness of care delivered, the CPCP amounts will be larger than the FFS payment amounts they are intended to replace.”<sup>12</sup>
- **Oncology Care Model (OCM)-Two-Sided Risk-** The Oncology Care Model aims to provide higher quality care at the same or reduced cost to Medicare through coordination of oncology care. According to CMS, “the goal of OCM is to utilize appropriately aligned financial incentives to enable improved care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy. OCM encourages participating practices to improve care and lower costs through an episode-based payment model that financially incentivizes high-quality, coordinated care. Practitioners in OCM are expected to rely on the most current medical evidence and shared decision-making with beneficiaries to inform their recommendation about whether a beneficiary should receive chemotherapy treatment. OCM provides an incentive to participating

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<sup>11</sup> Available online at <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

<sup>12</sup> See note 9 infra.

physician practices to comprehensively and appropriately address the complex care needs of the beneficiary population receiving chemotherapy treatment, and heighten the focus on furnishing services that specifically improve the patient experience or health outcomes.”<sup>13</sup>

- **Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)**- The CJR Payment Model was designed to improve quality of care for Medicare beneficiaries undergoing common inpatient surgeries such as hip and knee replacements. Participating hospitals were held financially accountable for quality and cost of care associated with surgery and incentivized to coordinate care among other hospitals, physicians, and post-acute care providers. The model was a qualified APM for 2017, but has been withdrawn by CMS for future years.<sup>14</sup>

### **Physician Technical Advisory Committee (PTAC)**

MACRA also created a physician Technical Advisory Committee (PTAC) to evaluate physician-focused APM proposals (PFPM). CMS is required to provide a detailed response to any physician led PTAC endorsed APM proposal. PTAC is composed of 11 members appointed by the Comptroller General of the United States. Members include both physicians and non-physicians, all of whom have expertise in PFPMs and delivery of care. PTAC evaluates stakeholder-submitted proposals against criteria established by the Secretary of HHS and makes recommendations regarding the future of those proposals. PTAC began receiving letters on intent on October 1, 2016, and full proposals on December 1, 2016. To date, PTAC has received 19 full proposals and has submitted five evaluations to the Secretary.

Additional information on PTACs is available online at <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>.

## **IV. STAFF CONTACTS**

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

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<sup>13</sup> Available online at <https://innovation.cms.gov/initiatives/Oncology-Care/>

<sup>14</sup> Available online at <https://innovation.cms.gov/initiatives/cjr>