ENERGY & COMMERCE
CHAIR RODGERS

MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee on Energy and Commerce Majority Staff
Re: Health Subcommittee Hearing on June 13, 2024

The Subcommittee on Health will hold a hearing on Thursday, June 13, 2024, at 10:00 a.m. (ET) in 2123 Rayburn House Office Building. The title of the hearing is "Checking-In on CMMI: Assessing the Transition to Value-Based Care."

I. Witness

- **Dr. Elizabeth Fowler, Ph.D., J.D.,** Deputy Administrator and Director, Center for Medicare and Medicaid Innovation (CMMI)

II. Background

The Center for Medicare and Medicaid Innovation (CMMI) was established by the Affordable Care Act (ACA) in 2010. The goal of CMMI has been to design and test innovative payment and service delivery models in health care to address rising costs, quality of care, and inefficient spending. CMMI is managed by the Centers for Medicare and Medicaid Services (CMS) and receives $10 billion of mandatory funding every ten years.

The models tested by CMMI can be applied to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[1] The payment and care delivery models can be implemented nationwide, or limited to specific regions, or states, and can be both voluntary and mandatory for providers to utilize. Furthermore, the only statutory requirement for creating a model is that the model must serve populations for which "deficits in care" lead to poor clinical outcomes or potentially avoidable expenditures. However, the Chief Actuary of CMS must certify a model is expected to improve quality, reduce spending, or both before a model can be implemented.[2]

To date, CMMI has launched over 50 models, with around 30 still in operation today. Only 6 models have ever delivered significant savings, net of any participation incentive, while 2 of these models have shown significant quality improvements.[3] CMMI tests its models through a two-phase demonstration process: Phase I, Model Testing and Evaluation, and Phase II, Model

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[1] Avalere, "What is the CMS Innovation Center?", 2023. https://avalere.com/insights/what-is-the-cms-innovation-center#:~:text=The%20Affordable%20Care%20Act%20(ACA,or%20improving%20quality%20of%20care.
[2] 42 U.S.C. 1315a. https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[3] Center for Medicare and Medicaid Innovation, "2022 Report to Congress", 2022. https://www.cms.gov/priorities/innovation/data-and-reports/2022/rtc-2022

Expansion Determination. So far, only four tested models have met the eligibility criteria to be considered for expansion.[4]

In 2021, CMS published a White Paper titled "Driving Health System Transformation-A Strategy for the CMS Innovation Center's Second Decade."[5] In this paper, CMMI established a new CMS Innovation Center Vision – "a health system that achieves equitable outcomes through high-quality, affordable, and person-center care." To achieve this goal, CMMI identified five new strategic objectives: 1) Drive Accountable Care, 2) Advance Health Equity, 3) Support Care Innovations, 4) Improve Access by Addressing Affordability, and 5) Partner to Achieve System Transformation.

CBO Analysis:

The creation of CMMI was projected to save $1.3 billion over the first 10 years when passed as part of the ACA.[6] Subsequent, the Congressional Budget Office (CBO) estimated that CMMI would save $34 billion in health care costs on net from 2017 to 2026, despite facing the large upfront costs.[7] However, in September 2023, CBO released analysis showing that CMMI's activities resulted in increased federal spending of $5.4 billion between 2011 and 2020. In total, CMMI spent $7.9 billion to operate models that only reduced spending by $2.6 billion. This updated CBO analysis projected CMMI to increase federal spending by $1.3 billion between 2021 and 2030. This projection was not based on an evaluation of specific models currently in place, but rather based on program level assumptions.

Medicare's Transition to Value-Based Care:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) gave CMMI a central role in Medicare's transition to value-based health care. MACRA established the Quality Payment Program (QPP), which was designed to reward physicians who provided the highest quality of care with financial incentives and reduced payments to physicians who fell short of the program's goals.[8] The QPP consists of two parts, the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs). MIPS was designed to consolidate the various quality measurement programs across Medicare into one system. However, by doing so, many providers have found MIPS requirements unnecessarily burdensome, overly broad, and not applicable to the care they are providing. While MIPS was designed to be more general in the measure of quality and application of value-based care, APMs were designed to reward high-quality care with more specificity. APMs can be designed around treating a specific health condition (e.g. end-stage renal disease), particular care episode (e.g.

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[4] *Id.*
[5] Centers for Medicare and Medicaid Services, "Driving Health System Transformation—A Strategy for the CMS Innovation Center's Second Decade", 2021. https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper
[6] Congressional Budget Office, *Letter on 2010 Reconciliation Proposal Budgetary Projections*, 2010. https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf
[7] Congressional Budget Office, "Federal Budgetary Effects of the Activities of the Center for Medicare and Medicaid Innovation", 2023. https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf
[8] Congressional Research Service, "The Medicare Access and CHIP Reauthorization Act of 2015", 2015. https://www.crs.gov/Reports/R43962?source=search

joint replacement), provider type (e.g. primary care providers or a particular physician specialty), or community (e.g. rural areas). Physicians can be exempt from MIPS requirements if they become a Qualified Provider in an Advanced Alternative Payment Model.

Congress entrusted CMMI to oversee the development and management of APMs. To help with the creation of APMs, Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to work with provider groups in developing and ultimately recommending potential APM models to CMMI for approval. This pathway was designed to allow providers who were eager for the opportunity to participate in an APM the chance to design a model that made sense for their practice while still promoting the principles of value-based care. However, to date there are only 14 APMs and not a single APM that was developed through the PTAC pathway has ever been tested. Provider participation in APMs has increased overall, but still falls far short of MIPS, with 386,263 qualifying as an APM provider in 2022 compared to the 624,209 clinicians in the MIPS program.[9]

III. Staff Contacts

If you have questions regarding this hearing, please contact Emma Schultheis of the Committee staff at (202) 225-3641.

[9] Centers for Medicare and Medicaid Services, "Quality Payment Program (QPP) 2022 Participation and Performance Results At-a-Glance", 2022.