STATEMENT OF

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ON

IMPLEMENTATION OF MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

BEFORE THE

U.S. HOUSE COMMITTEE ON WAYS & MEANS

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"Implementation of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)"

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Chairman Tiberi, Ranking Member McDermott, 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). We greatly appreciate your leadership in passing this important law, which provides a new opportunity for CMS to partner with physicians and clinicians to support quality improvement and develop new payment models to further our shared goals of a health care system that achieves better care, smarter spending, and healthier people and puts empowered and engaged consumers at the center of their care. As we take our initial steps to implement this important law, we have and will continue to work closely with you and listen to the physicians and clinicians providing care to Medicare beneficiaries, with the goal of creating a new payment program that is focused on the needs of patients and responsive to the day-to-day challenges and opportunities within physician practices. As we continue to transform the Medicare program, we are working to move beyond "one size fits all" measurements to an approach that offers multiple paths to value-driven care and recognizes and supports the diversity of medical practices that serve Medicare beneficiaries.

Today, over 55 million Americans are covered by Medicare[1] — and 10,000 become eligible for Medicare every day. [2] For most of the past fifty years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered. In the last few years, we have made tremendous progress to transform our nation's health care system into one that works better for everyone and rewards value over volume. Key to this effort is changing how we pay physicians and other clinicians, so they can focus on the quality of care they give, and not the quantity of services they order. Already, we estimate that 30 percent of

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-28.html

[2] http://www.medpac.gov/documents/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-(june-2015-report).pdf?sfvrsn=0

traditional Medicare payments are tied to alternative payment models (APMs). 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 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. This is a major milestone in the continued effort towards improving quality and care coordination. We expect this progress to continue, and we are on track to meet our goal of tying 50 percent of traditional Medicare payments to APMs by 2018 – especially in light of MACRA or the "Quality Payment Program."

The enactment of MACRA, which replaced the Sustainable Growth Rate (SGR) formula with a more sustainable way for paying physicians and other clinicians, provided new tools to modernize Medicare and opportunities to simplify quality programs and payments for these professionals. Currently, Medicare measures the value and quality of care provided by physicians and other clinicians through a patchwork of programs. Some clinicians are part of APMs such as the Accountable Care Organizations (ACOs), the Comprehensive Primary Care Initiative, and the Medicare Shared Savings Program—and most participate in programs such as the Physician Quality Reporting System, Physician Value-based Payment Modifier ("Value Modifier Program"), and the Medicare Electronic Health Record (EHR) Incentive Program. Thanks to Congress, MACRA streamlined these various programs into a single framework where clinicians have the opportunity to be paid more for providing better value and better care for their patients. CMS has proposed to implement these changes through the unified framework called the Quality Payment Program.

The Quality Payment Program gives physicians and clinicians the flexibility to participate in one of two paths. First, the Merit-based Incentive Payment System (MIPS) streamlines the three existing CMS programs into a single, simplified program with lower reporting burden and new flexibility in the way clinicians are measured on performance. MIPS allows Medicare clinicians to be paid for providing high value care through success in four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities, and Cost.

For physicians and clinicians who take a further step towards care transformation, the Quality Payment Program rewards physicians and clinicians through the second path, participation in Advanced APMs. Under Advanced APMs, physicians and clinicians accept more than a nominal amount of risk for providing coordinated, high-quality care for a set portion of their practice, such as Tracks 2 and 3 of the Medicare Shared Savings Program and the Next Generation ACO model.

Since the enactment of MACRA a little over a year ago, CMS has been developing our approach to implementation, and on April 27, 2016, CMS issued a Notice of Proposed Rule Making (NPRM).[3] CMS developed a proposal based on vital stakeholder feedback and input from the health care community. In our efforts to draft a proposal that would be simpler and meaningful for physicians and clinicians, we reached out and listened to over 6,000 stakeholders, including state medical societies, physician groups, consumer groups, and federal partners. We asked for comments[4] from the stakeholder community on key topics related to how to develop the measurements, scoring, and public reporting for the Quality Payment Program. We conducted multi-day workshops, and visited with physicians in their communities individually and in groups to understand how the changes we considered may positively impact care and how to avoid unintended consequences.

The input we have received from stakeholders has been invaluable and nearly universal: physicians and clinicians want support for a care system that improves coordination and reduces cost, but too many unaligned quality programs, measures, and technology requirements can hinder their best efforts to accomplish these goals. Based on what we learned, our approach to implementation has been guided by three principles. First, patients are, and must remain, the key focus. Financial incentives should work in the background to support physician and clinician efforts to provide high quality services, and the needs of the patient, not measurements, need to be the focus of our approach. Second, success will come from adopting approaches that are practice-driven. Quality measurement needs to accurately reflect the needs of a diverse range of patient populations and practice types and give physicians and clinicians the opportunity to select

[3] http://federalregister.gov/a/2016-10032
[4] http://federalregister.gov/a/2015-24906

elements of the program and measures that are right for their practice. Third, in everything we do, we must strive to make care delivery as simple as possible, with more support for collaboration and communication through delivery system reform. We know that physicians and clinicians strive to provide the best possible care for patients, and they deserve a program that encourages them to do so with flexible requirements that are as simple as possible while meeting standards of care that represent the highest quality of medicine and provide high value for the Medicare program. Among the many topics on which we seek feedback in the proposed rule during the comment period, this is among the most important, especially as we seek to create and enhance opportunities for small and rural practices while reducing administrative burden. .

We relied heavily on stakeholder input we received over the last year to inform our proposal of a scoring methodology for MIPS that aims to improve upon and streamline existing measures in the quality, cost, and advancing care information categories, which are based in part upon current CMS programs. In particular, we have been working side-by-side with the physician and consumer communities to address needs and concerns about the Medicare EHR Incentive Program, often known as Meaningful Use for physicians, as we transition it to the Advancing Care Information category in MIPS. The new approach heightens focus on the patient, increases flexibility, reduces burden, and concentrates on aspects of health information technology, such as health information exchange, that are critical for delivery system reform and improving patient outcomes. We also used this feedback when proposing the new clinical practice improvement activities category, which the statute created. When developing the proposed activities for this category, we listened closely to specialty societies and associations when creating options to allow clinicians to select activities that match their practices' goals.

While we expect that most clinicians will participate in MIPS for the first years of the Quality Payment Program, we will continuously search for opportunities to expand and refine our portfolio of payment models in order to maximize the number of physicians and clinicians who have the opportunity to participate in Advanced APMs. It is our intent to align the MIPS and the Advanced APM components of the Quality Payment Program, allowing maximum flexibility for clinicians to switch between MIPS and participation in Advanced APMs based on what works best for them and their patients.

The proposed rule is the latest step in our efforts to work in concert with stakeholders on the front-line of care delivery to draw upon their expertise and incorporate their input into the policies for the Quality Payment Program so that together, we can achieve the aim of the law. We eagerly anticipate comment on our proposal from all stakeholders and look forward to reviewing responses. Just as stakeholder input has been instrumental in the development of the proposed rule, the feedback we receive will be essential in our development of final regulations.

Notice of Proposed Rule Making (NPRM)

In our proposed rule, we provide details and descriptions of the proposed policies that will allow us to implement the important new provider payment provisions included in MACRA.

Merit-based Incentive Payment System (MIPS)

Currently, Medicare measures doctors and other clinicians on how they provide patient quality and reduce costs through a patchwork of programs, with clinicians reporting through some combination of the Physician Quality Reporting System, the Value Modifier Program, and the Medicare EHR Incentive Program. Through the law, Congress streamlined and improved these reporting programs into the Merit-based Incentive Payment System. Under MIPS, eligible physicians and clinicians will report their performance under four categories and will receive a payment adjustment based on their overall performance.

Consistent with the goals of the law, the proposed rule would improve the relevance of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. Under our proposed rule, performance measurement under the new program for physicians and other eligible clinicians would begin in 2017, with payments based on those measures beginning in 2019. MIPS allows Medicare clinicians to be paid for providing high quality, efficient care through success in four performance categories:

1. **Quality (50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program)**: Clinicians would choose to report six measures versus the nine measures currently

required under the Physician Quality Reporting System. This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.

2. **Advancing Care Information (25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as "Meaningful Use"):** Clinicians would choose to report customizable measures that reflect how they use EHR technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing Meaningful Use program, this category would not require all-or-nothing EHR measurement or quality reporting.
3. **Clinical Practice Improvement Activities (15 percent of total score in year 1)**: Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in APMs and in Patient-Centered Medical Homes.
4. **Cost (10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use):** The score would be based on Medicare claims and require no reporting by physicians or other clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.

The law requires MIPS to be budget neutral. Therefore, physicians' and clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent; the positive adjustments will be scaled up or down to achieve budget neutrality. Also, in the first six years of the program, additional bonuses are provided for exceptional performance.

Advanced Alternative Payment Models (APMs)

For clinicians who take a further step towards care transformation, the law creates another path. Physicians and clinicians who participate to a sufficient extent in Advanced Alternative Payment Models would qualify for incentive payments. Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a physician or clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Under the law, Advanced APMs are those in which clinicians accept risk and reward for providing coordinated, high-quality, and efficient care. As proposed, Advanced APMs must generally:

1. **Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures. We propose that the amount of risk must meet the following standards:
    - Total risk (maximum amount of losses possible under the Advanced APM) must be at least 4 percent of the APM spending target.
    - Marginal risk (the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM is responsible; i.e., sharing rate) must be at least 30 percent.
    - Minimum loss rate (the amount by which spending can exceed the APM benchmark (or bundle target price) before the Advanced APM has responsibility for losses) must be no greater than 4 percent.
2. **Base payments on quality measures comparable to those used in the MIPS quality performance category.** To meet this statutory requirement, we propose that an Advanced APM must base payment on quality measures that are evidence-based, reliable, and valid. In addition, at least one such measure must be an outcome measure if

an outcome measure appropriate to the Advanced APM is available on the MIPS measure list.

3. **Require participants to use certified EHR technology.** To meet this requirement, we propose that an Advanced APM must require that at least 50 percent of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. This requirement increases to 75 percent in the second performance year.

In addition, under the statute, medical home models that have been expanded under the Innovation Center authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While medical home models have not yet been expanded, the proposed rule lays out criteria for medical home models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

The rule proposes a definition of medical home models, which focus on primary care and accountability for empaneled patients across the continuum of care. Because medical homes tend to have less experience with financial risk than larger organizations and limited capability to sustain substantial losses, we propose unique Advanced APM financial risk standards, consistent with the statute, to accommodate medical homes that are part of organizations with 50 or fewer clinicians.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule as Advanced APMs. These include:

- Comprehensive ESRD Care (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program – Track 2
- Medicare Shared Savings Program – Track 3
- Next Generation ACO Model
- Oncology Care Model – Two-sided risk (available in 2018)

Under the proposed rule, CMS would update this list annually to add new payment models that qualify. CMS will continue to modify models in coming years to help them qualify as Advanced

APMs. In addition, starting in performance year 2019, clinicians could qualify for incentive payments based in part on participation in Advanced APMs developed by non-Medicare payers, such as private insurers, Medicare Advantage plans, or state Medicaid programs.

We recognize the substantial time and money commitments in which APM participants invest in order to become successful participants. Under the proposed rule, physicians and clinicians who participate in Advanced APMs but do not meet the law's criteria for sufficient participation in Advanced APMs, and those who participate in certain non-Advanced APMs, would be exempt from the cost category in MIPS, would be able to use their APM quality reporting for the MIPS quality category, and would receive credit toward their score in the Clinical Practice Improvement Activities category. We want to make sure that in addition to encouraging physicians and clinicians to improve quality of care by participating in APMs that best fit their practice and patient needs, physicians and clinicians are not subject to duplicate, overly burdensome reporting requirements.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

To help spur innovation for models that meet the needs of the physician community, MACRA established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will meet at least a quarterly 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 eleven 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 PTAC has met twice and presentations from the meeting are available online.[5] I personally attended the second meeting on May 4, 2016. CMS looks forward to receiving these critical recommendations for new physician-focused payment models. We encourage physician specialists and other stakeholders to engage with the PTAC to suggest well designed, robust models. We are committed to working closely with the PTAC and are looking forward to reviewing their recommendations.

[5] 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 transitioning to the MIPS and we want to make sure that they have the tools they need to succeed in a redesigned system. 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 Quality Improvement Organizations, regional extension centers, and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to prepare for and set up support for physicians and clinicians to be successful under MIPS criteria, making it as seamless as possible for these clinicians and practices to comply with MIPS requirements while 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, and details regarding the technical assistance program will be addressed in future guidance.

In addition to MACRA implementation efforts, 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 more fully rewarding the value and quality of services provided by physicians and other clinicians, not just the quantity of such services. For it to be successful - in other words, for MACRA to improve care delivery and lower health care costs – we must first demonstrate to clinicians and patients both the value of these new payment programs established by MACRA and the opportunity for them to shape the health care system of the future. The program must be flexible, practice-driven, and patient-centered. It must

contain achievable measures; it must support the continued development of health IT infrastructure through interoperability; it must engage and educate physicians and others clinicians; and it must promote and reward improvement over time.

Our proposed rule incorporates input received to date, but it is only a first step in an iterative process for implementing the new law. Moving forward, we will continue to gather feedback to inform an implementation approach that leads to better care, smarter spending, and improved patient outcomes. We will continue partnering with Congress, physicians and other providers, consumers, and other stakeholders across the nation to make a transformed and improved health system a reality for all Americans. We look forward to working with you as we continue to implement this seminal law.