THIS TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING WEDNESDAY MARCH 21, 2018 AT 2:00 PM

STATEMENT OF

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ON

THE IMPLEMENTATION OF MACRA'S PHYSICIAN PAYMENT POLICIES

BEFORE THE

U. S. HOUSE COMMITTEE ON WAYS & MEANS,
SUBCOMMITTEE ON HEALTH

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U. S. House Committee on Ways & Means,
Subcommittee on Health
"The Implementation of MACRA's Physician Payment Policies"
March 21, 2018

Chairman Roskam, Ranking Member Levin, 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 transform our healthcare system from one that pays for procedures and sickness to one that pays for better value and improved outcomes by empowering patients and reducing clinician burden. These principles are our key focus as we work to implement the Congress's vision for Medicare clinician payment in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The goal of a value-based transformation of our entire healthcare system has been a longstanding one but often this transformation has been a frustrating process for clinicians. We have not yet fully realized the promise of MACRA. Too few physicians and clinicians are participating in alternative payment models, and far too many clinicians found the law's reporting requirements too burdensome. Nevertheless, we cannot turn back to an unsustainable system that pays for procedures rather than value. We must move forward on four areas of emphasis: giving consumers greater control over health information through interoperable and accessible health information technology; encouraging transparency from payers and providers; using experimental models in Medicare and Medicaid to help patients drive value and quality throughout the entire system; and removing government burdens that impede this transformation.

We know this transformation -- and MACRA in particular -- is a big change for clinicians and their patients, but CMS is committed to promoting market based competition, interoperability, and transparency to make sure that patients are in the driver's seat, making their own determinations about the value and quality of the care they receive. We want to support patients by using data driven insights, increasingly aligned and meaningful quality measures, and innovative technology. CMS is working hard to evaluate and streamline regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the patient experience by allowing their healthcare providers to spend more time with them. CMS has launched the

"Patients over Paperwork" initiative[1], which is consistent with President Trump's Executive Order, which recognizes the importance of managing costs associated with Federal regulations. Through "Patients over Paperwork," CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. In carrying out this internal process, CMS is removing regulatory obstacles that get in the way of clinicians spending time with patients.

One area that clinicians have told us that we can offer relief is around how they report quality and other measures to us at CMS. Far too many clinicians have also told us they feel these measures do not accurately reflect their interactions with their patients nor do they provide substantive feedback. Until we get to a smaller set of more impactful measures that assess outcomes rather than processes, the burden associated with reporting measures will run the risk of outweighing their intended purpose.

In response to these concerns and feedback from patients and clinicians, CMS developed the Meaningful Measures initiative[2] to identify the highest priorities for quality measurement and improvement. It involves only assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes. The Meaningful Measure Areas serve as the connectors between CMS goals under development and individual measures/initiatives that demonstrate how high quality outcomes for our beneficiaries are being achieved. To the extent that legislation requires us to measure quality, we want to pick measures that reflect patients' choices and outcomes instead of process and other "check-the-box" measures that offer no real value to the patient. We're committed to measuring quality without increasing burden. To decrease the reporting burden for clinicians, we will utilize measures drawing on data from claims, registries, or electronic health records where possible. We continue to seek feedback from clinicians on how we can simplify documentation requirements and other paperwork that

[1] For more information: https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html

can get between a physician and their patients, including creating a virtual "suggestion box" that allows healthcare providers to share their ideas.[3]

CMS is bringing all of these principles and approaches together as we work to implement Congress' vision of a fundamental reorientation of how Medicare pays for clinician services. We want to create a true competitive playing field where value is rewarded and the patient makes the decisions. This transformation to a competitive, value-based marketplace will require innovative ideas, approaches, and solutions from outside of Washington.

The Quality Payment Program (QPP)

With the leadership of this Committee and others in Congress, MACRA repealed the flawed Sustainable Growth Rate (SGR) formula, which put clinicians at the risk of cuts in Medicare payments, and replaced it with a new program that CMS calls the Quality Payment Program. CMS appreciates Congress' continued leadership and engagement as we implement the Quality Payment Program, particularly the additional flexibilities granted as a part of the recently enacted Bipartisan Budget Act of 2018[4] (PL 115-123). These flexibilities will ensure CMS is able to continue our implementation work by minimizing the burden on clinicians.

Like any new program requiring significant changes to the way clinicians are incentivized within Medicare, the Quality Payment Program has faced significant barriers to achieving the well-intended goals it was designed to accomplish. Congress specified in MACRA that most clinicians who furnish items and services paid under Medicare Part B would be subject to payment incentives under one of two paths: the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (Advanced APMs). Clinicians face unique challenges under each path, whether they work alone or in groups to meet the MIPS requirements and earn a payment adjustment or whether they take on financial risk in Advanced APMs to potentially earn an APM incentive payment and be excluded from the MIPS reporting requirements and payment adjustment.

[3] ReducingProviderBurden@cms.hhs.gov.
[4] https://www.congress.gov/bill/115th-congress/house-bill/1892/

The President's FY 2019 budget[5] included a proposal to further simplify and reduce the reporting burden under the MIPS for physicians and other clinicians by proposing to adopt broader claims and beneficiary survey calculated measures that assess clinician performance in the quality performance and cost categories at the group-level only. This proposal would use payment adjustments under the current statute and would retain the $500 million in annual additional positive payment adjustments for top performers.

Implementing the Merit-based Incentive Payment System (MIPS)

The principal way that MIPS measures quality of care is through a set of quality measures from which MIPS eligible clinicians can select. Congress created four statutory pillars of the MIPS incentive structure: the performance categories of Quality; Improvement Activities; Advancing Care Information (based on the Medicare Electronic Health Record Incentive Program); and Cost. Clinicians will earn a payment adjustment based on information they submit or CMS determines from claims, demonstrating that they provided high quality, efficient care.

MIPS began with the first performance period in 2017 (Year One), during which clinicians were able to "pick their pace" and choose when and which performance data they submit to CMS. In the first year of the program, the cost category was not included in the final score. Depending on what Year One data a clinician submits, their 2019 Medicare payments could be adjusted. For example, if a clinician reports that they have completed one quality measure or one improvement activity, they will be able to avoid a downward payment adjustment. If a clinician submits partial Year One data (at least 90 days) they can earn a neutral or positive payment adjustment. Those clinicians who submit a full year of Year One data may earn a higher positive payment adjustment. Those who do not submit any Year One data will receive a negative four percent payment adjustment.

CMS launched a new data submission system for clinicians in MIPS, and eligible clinicians are now submitting their Year One data. The new data submission system is an improvement from the systems under the former Medicare quality programs, which required clinicians to submit

[5] https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf

data on multiple websites. The new data submission system makes it easier for clinicians to meet the Quality Payment Program's reporting requirements and spend more time treating patients instead of filling out paperwork. For example, we are providing clinicians multiple data submission options, including existing data registries, which they already utilize. Eligible clinicians can also submit data using a Health IT Vendor, which extracts data from certified electronic health record technology; however, in the spirit of flexibility and burden reduction, eligible clinicians can also choose to manually upload their data into the submission system. As data is entered into the system, eligible clinicians will be able to see real-time initial scoring within each of the MIPS performance categories based on their submissions. Once the submission period closes, we will calculate payment adjustments based on the clinician's last submission or submission update.

CMS recognizes the Quality Payment Program is a big change. Calendar Year 2018 marks the second performance period (Year Two), and CMS is offering additional flexibility to clinicians to help meet the Quality Payment Program's reporting requirements. Consistent with this Administration's goal of reducing clinician burden and putting patients first, in the Year Two final rule with comment period[6], we slowed the ramp-up of the Quality Payment Program by establishing special policies for MIPS aimed at encouraging successful participation in the program by reducing burden, and reducing the number of clinicians required to participate. We have also implemented additional hardship exceptions, focused on flexibility for small and rural practices, and provided a scoring adjustment to account for clinicians that treat complex patients. Our hope is for the program to evolve to the point where all the clinical activities captured in MIPS across the four performance categories reflect the goal of promoting market based competition, interoperability, and transparency by making sure that patients are in the driver's seat.

Additionally, concurrent with the 2018 rulemaking for the second year of the program, CMS also published an interim final rule with comment period to establish an automatic extreme and uncontrollable circumstance policy for the 2017 MIPS performance period. This policy

[6] https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme

recognizes that recent hurricanes (Harvey, Irma, and Maria) and other natural disasters can effectively impede a MIPS eligible clinician's ability to participate in MIPS and relieves reporting requirements for clinicians who are located in affected areas.

CMS will continue its gradual and measured approach to implementation of MIPS, following the provisions of the recently enacted Bipartisan Budget Act of 2018, where Congress granted additional flexibilities. These provisions give CMS additional flexibility in determining the MIPS Performance Threshold for three additional years, provide CMS flexibility in determining weight for the MIPS cost performance category, and restrict applicability of the MIPS payment adjustments to covered professional services under the Physician Fee Schedule. As we continue to refine and improve the Quality Payment Program and look to reduce clinician burden, our focus is on integrating this new program into clinicians' existing workflows to ensure smooth implementation and minimizing any disruption to patient care.

Encouraging Participation In Advanced Alternative Payment Models (Advanced APMs)

In addition to carefully and deliberately implementing the new requirements of the Quality Payment Program for MIPS, CMS has focused on developing Advanced APMs. Congress established the criteria for "Advanced APMs." Clinicians with sufficient participation in Advanced APMs during a performance year receive a five percent APM incentive payment for payment years through 2024. It is our belief that MIPS builds the capacity of eligible clinicians across the four pillars of MIPS to prepare them for participation in APMs in later years of the Quality Payment Program.

Advanced APMs are those that require participants to bear a certain amount of financial risk, base payments for clinicians' services on MIPS-comparable quality measures, and require participants to use certified electronic health record technology. Unfortunately, the process to develop new models, including those that are Advanced APMs is extensive and lengthy. This has resulted in too few Advanced APMs. CMS is testing or has announced for future testing only ten Advanced APMs and too few of those include specialty clinicians. In the QPP Year 2 Final Rule, CMS estimated that 185,000 to 250,000 will be eligible to receive the five percent APM incentive payment and be exempt from MIPS reporting requirements, based on the 2018

performance period. If we want to realize the full promise of MACRA and Advanced APMs we need to do more.

CMS is working to develop new Advanced APMs and providing resources and assistance to help clinicians wishing to participate in Advanced APMs, so they have the opportunity to earn the APM incentive payment each year and be excluded from the MIPS reporting requirements and payment adjustment. We want to work to provide as much clarity and flexibility as possible to achieve the goals of improving health outcomes, promoting efficiency, minimizing the burden of participation, and providing fairness and transparency in operations.

In addition to encouraging clinician participation in Advanced APMs with Medicare, Congress also created the All-Payer Combination Option that offers clinicians another way to earn the five percent APM incentive payment (and exclusion from the MIPS reporting requirements and payment adjustment) based on combined participation in both Advanced APMs and Other Payer Advanced APMs, which are alternative payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans, payers in CMS Multi-Payer Models[7], and other commercial payers. In the 2018 rulemaking for the Quality Payment Program, we established policies to implement the All-Payer Combination Option in 2019. Where possible, we have created additional flexibilities and alternatives to allow clinicians to be successful under the All-Payer Combination Option.

Within CMS, the Center for Medicare and Medicaid Innovation (Innovation Center) bears primary responsibility for developing Advanced APMs. The Innovation Center's statutory authority allows CMS to test innovative payment and service delivery models expected to reduce expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

[7] CMS Multi-Payer Models means an Advanced APM that CMS determines, per the terms of the Advanced APM, has at least one other payer arrangement that is designed to align with the terms of that Advanced APM. An example of a CMS Multi-Payer Model is the Comprehensive Primary Care Plus Model.

CMS has a responsibility to make sure the models we design for testing are data driven, include appropriate beneficiary and program integrity protections, and meet the statutory requirements for the testing of models.

Our existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons and CMS is setting a new direction for the Innovation Center. That is why, in September 2017, CMS released a Request for Information[8] (RFI) seeking public feedback on ways to promote patient-driven care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The RFI asked for input on ways to increase opportunities for eligible clinicians to participate in Advanced APMs and meet eligibility requirements to receive the APM incentive payment. For example, we asked for feedback on how CMS can be more responsive to eligible clinicians and their patients while expediting the process for clinicians that want to participate in an Advanced APM. We also asked for guidance from stakeholders on ways to capture appropriate data to drive the design of innovative payment models and strategies to incentivize eligible clinicians to participate in Advanced APMs.

We are grateful for the comments and thoughtful ideas that we received in response to the RFI. Overall, through the close of the comment period in November, CMS received approximately 1000 submissions. We continue to review these submissions, and they will be an integral source of information as CMS moves forward with our agency-wide efforts to promote innovation, including through the creation of additional Advanced APMs that will improve the patient-provider experience. However, our engagement with stakeholders has not ended with this RFI and we look forward to continuing to working with all stakeholders to make sure we're delivering results and putting the patient in the driver's seat.

[8] https://innovation.cms.gov/Files/x/newdirection-rfi.pdf

Facilitating the Development of New APMs

Although CMS has taken steps to gather and incorporate ideas regarding Advanced APMs, we know we can do better. Depending on the model, APMs generally take the Innovation Center 18 months to design and launch, and we have heard from stakeholders that the current process for announcing new models that would qualify as Advanced APMs is too lengthy. A model's lifecycle includes model design, testing, evaluation, and expansion, if the statutory requirements for expansion are met. For example, once the Innovation Center identifies innovative payment or service delivery models that show promise, the Innovation Center has to determine the appropriate payment methodology and update CMS systems, identify the appropriate performance measures and the means to collect them, consider how to engage beneficiaries, and identify technical assistance or learning opportunities that participants might need to implement their participation in the model. We may use additional Requests for Information and listening sessions to allow the public and stakeholders to help us hone ideas into testable models. Due to the time needed for these activities, only ten APMs currently qualify as Advanced APMs[9], and many of these are not aimed at specialists.

CMS' portfolio of APMs currently includes the following ten models and programs that are considered Advanced APMs: the Next Generation ACO Model, the Comprehensive End Stage Renal Disease Care Model (two-sided risk track), the Oncology Care Model (two-sided risk track), the Comprehensive Care for Joint Replacement Model (Track 1-CEHRT), the Comprehensive Primary Care Plus Model, the Medicare ACO Track 1+ Model, the Vermont Medicare ACO Initiative[10], the Medicare Shared Savings Program Track Two, the Medicare Shared Savings Program Track Three, and the recently announced Bundled Payments for Care Improvement Advanced Model (BPCI Advanced), which will be an Advanced APM in 2019. In addition, we are exploring options to develop a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative alternative payment

[9] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf. Tracks 2 and 3 of the Medicare Shared Savings Program are Advanced APMs. The Medicare Shared Savings Program is a national program established in statute and is not tested by the Innovation Center.

[10] Vermont ACOs will be participating in an Advanced APM during 2018 through their participation in a version of the Next Generation ACO Model. We anticipate the Vermont Medicare ACO Initiative will separately be an Advanced APM beginning in 2019.

arrangements under Medicare Advantage. We believe this is especially important for eligible clinicians who do not participate in Advanced APMs under fee-for-service Medicare.

We expect that the number of eligible clinicians choosing to participate in Advanced APMs will grow over time, and we are working hard to facilitate this growth by developing more models. We are also examining ways to increase the availability of specialty physician models to engage specialty physicians, especially for independent physician practices.

We are also working to improve model operations once testing begins and to more quickly evaluate results from models. Currently, once a model test begins, model participants often find that the first year of a model test is dedicated to becoming familiar with the model requirements and adapting how to implement them in the most effective way for the particular hospital, state, ACO, or other model participant. In addition, participant claims or state data are usually not available to CMS until several months or more after the services are provided. These issues can lead to a delay in the evaluator's ability to identify statistically significant findings and to determine which models meet the statutory requirements for expansion. The goal of the Innovation Center is to test models that meet the statutory requirement for expansion. Models may only be expanded if the CMS Chief Actuary certifies that the expansion would reduce or not result in any increase in net program spending and if the Secretary determines that the expansion is expected to either reduce program spending without reducing the quality of care or improve the quality of patient care without increasing spending and that such expansion would not deny or limit the coverage or provision of benefits.

In addition, it is possible that the complexity of certain models might contribute to consolidation within the healthcare system, leading to fewer choices for patients. But, strengthening the healthcare system will require healthcare providers to compete for patients in a free and dynamic market. We seek to test models that promote competition, based on quality, outcomes, and costs.

We continue to consider ways to further promote the goals of promoting market based competition, interoperability, and transparency by making sure that patients are in the driver's seat, making their own determinations about the value and quality of the care they receive. The President's FY 2019 Budget also proposes to eliminate arbitrary thresholds and other burdens to

encourage participation in Advanced APMs. This proposal would modify how the five percent APM incentive payment is determined in order to better reward clinicians who participate in Advanced APMs. Instead of receiving a five percent incentive payment on all Physician Fee Schedule payments if they meet or exceed the payment or patient thresholds as under current law and regulations, clinicians would receive a five percent APM incentive payment on Physician Fee Schedule revenues received through the Advanced APMs in which they participate. This change directly rewards clinicians along a continuum based on their level of participation in Advanced APMs, without subjecting clinicians to arbitrary participation threshold levels. We believe this change will encourage more clinicians to participate in Advanced APMs to the benefit of their patients.

Working with Stakeholders

CMS welcomes innovation, and we encourage anyone with a promising idea to submit it to the Innovation Center for consideration. We have an Alternative Payment Model Design Toolkit[11] available through our website, which provides a detailed and comprehensive set of resources to help design a proposed APM. For example, it lays out how the Innovation Center assesses ideas for new models, including descriptions of model design and evaluability factors, and includes instructions for submitting an idea through the Innovation Center website.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Another important source for new, innovative APMs is the Physician-Focused Payment Model Technical Advisory Committee (PTAC). MACRA established the PTAC to review and assess stakeholder proposals for physician-focused payment models. The Secretary established criteria for physician-focused payment models, which include categories to promote payment incentives for higher-value care; to address care delivery improvements that promote better care coordination, protect patient safety, and encourage patient engagement; and to address information enhancements that improve the availability of information to guide decision-making. PTAC uses these criteria in reviewing these proposals and providing comments and recommendations to the Secretary. We believe that proposals submitted to the PTAC could fill

[11] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Alternative-Payment-Model-APM-Design-Toolkit.pdf

gaps in our current portfolio and ensure that clinicians are able to choose between several physician-focused payment models to find the right one for their practice. So far, the PTAC has submitted comments and recommendations to the Secretary on several proposals, and the Secretary's responses can be found on CMS's website.[12]

Health Care Payment Learning and Action Network (LAN)

The Health Care Payment Learning and Action Network (LAN) was launched to bring together stakeholders in the public and private sector to accelerate adoption of value-based payments and APMs. More than 4,800 patients, insurers, providers, states, consumer groups, employers, and other partners have participated in the LAN and over 50 organizations have made commitments to payment transformation. The mission of the LAN is to accelerate the healthcare system's transition to APMs by combining the innovation, power, and reach of the public and private sectors.

Moving Forward

As the Quality Payment Program moves through its second year, we want to ensure that there is meaningful measurement of value and quality, and that clinicians are not just being forced to check boxes. We want to make sure we are promoting better patient outcomes, improving coordination of care for patients, and supporting a simplified pathway to participation in MIPS and Advanced APMs.

Healthcare decisions should be made by those on the front lines – the patients, with healthcare providers and families of those directly involved with the care. CMS will continue to use the Quality Payment Program to promote greater flexibility and patient driven care. Our goal is to use the tools Congress gave us to allow clinicians to focus on patients over paperwork, and we are doing so by listening to innovators who know how to engineer a more efficient, market-driven healthcare system. Changes of this magnitude and complexity certainly pose challenges, and we remain committed to listening and engaging with clinicians and patients to hear what is working and how we can best fix what is not working. We know that we do not have all the answers in Washington and we look forward to continuing our work with this Committee,

[12] https://innovation.cms.gov/initiatives/pfpms/

members of Congress, clinicians, patients, entrepreneurs, and other stakeholders in order to find innovative ways to reduce provider burden, improve patient outcomes, curb rising costs, and empower patients.