THORN RUN PARTNERS
GOVERNMENT RELATIONS

Issue Brief: MACRA's Merit-based Incentive Payment System

January 12, 2016

I. EXECUTIVE SUMMARY

This Issue Brief provides an overview of key Medicare physician payment reforms to be implemented via the upcoming Merit-based Incentive Payment System (MIPS) pursuant to the latest "doc fix," the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10).[1]

Although MIPS – which entails a consolidation of three Medicare physician quality reporting initiatives – is not set to begin until January 1, 2019, the Centers for Medicare & Medicaid Services (CMS) has already taken steps toward implementation of the program, as detailed below. CMS expects to issue proposed rulemaking on various components related to the MIPS, including the release of the initial MIPS quality measure list (CMS-5517-P),[2] as early as next spring. More detailed information relative to broader MIPS implementation is expected to be promulgated in the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) proposed rule (see: CMS-1654-P[3]) due next summer.[4] Furthermore, through MIPS, CMS hopes to lay the groundwork for a broader value-based and quality-focused effort encompassing Alternative Payment Models (APMs), a topic of a forthcoming TRP Health Policy Issue Brief.

II. OVERVIEW OF MACRA: SGR REPEAL AND PROVIDER PAYMENT MODERNIZATION

Following sweeping bipartisan passage in the House and Senate, on April 14, 2015, the President signed into law MACRA, codifying permanent repeal and reform of Medicare's flawed Sustainable Growth Rate (SGR) formula. Following a total of 17 stop-gap "doc fixes" enacted since 2003, the SGR overhaul package averted a slated 21% reduction to Medicare physician payments and (finally) put to rest what had become a dreaded annual legislative ritual.

In addition to the Medicare physician payment reforms (see Sec. III), the legislation included important Medicare and Medicaid "extenders"; provided a two-year extension of the Children's Health Insurance Program (CHIP); and enacted a six-month enforcement delay of the "two-midnights" hospital policy (with the latest administrative extension through December 31, 2015), among other policy provisions.

[1] https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf
[2] http://resources.regulations.gov/public/custom/jsp/navigation/main.jsp
[3] Ibid.
[4] http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf (slide 8)

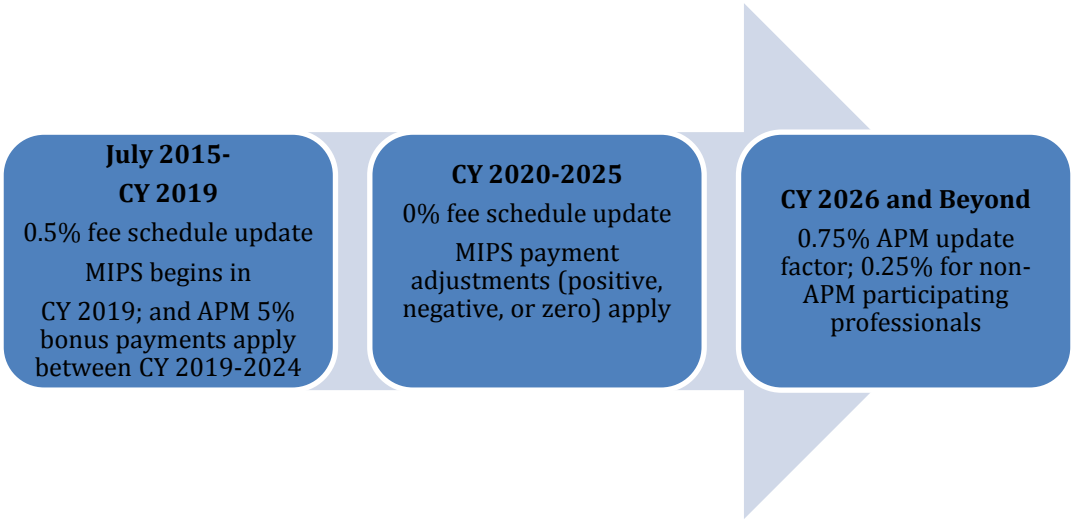
Roughly $70 billion of the $210 billion SGR package was offset, resulting in a $141 billion increase in federal budget deficits.[5] Offsets included further means-testing Medicare Part B and D premiums for certain higher-income beneficiaries, market basket cuts to certain Medicare post-acute care providers, payment reductions to hospitals, and other provisions.

III. MACRA's Two Payment Update Pathways: MIPS and APMs

MACRA repealed the SGR formula, replacing it with a five-year period of stability whereby physicians receive an annual Medicare payment update of 0.5% in CYs 2015 through 2019. Over the CY 2019-2025 period, Medicare payment rates will be predicated on eligible professionals' (EPs) participation in either: (1) MIPS or (2) Alternative Payment Models (APMs) (more to come in a forthcoming TRP issue brief).

Beginning in CY 2026 and subsequent years, in an effort to move toward full APM proliferation, Medicare professionals participating in APMs will receive annual updates of 0.75%; 0.25% updates will be provided to all other (non-APM participating) professionals. Of note, MACRA encourages EPs to move in this direction much sooner than CY 2026 via the provision of early incentives – i.e., providing a 5% annual bonus over the CY 2019-2024 period – for professionals who receive a "significant share" of revenue through an APM. The legislation is consistent with CMS' broader goal to tie roughly 30% of Medicare fee-for-service (FFS) payments to quality or value through APMs by the end of 2016 and 90% in broader value-based purchasing by the end of 2018.[6]

Figure 1: MACRA Physician Fee Schedule Updates (CYs 2015-2026 and Beyond)



[5] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr22.pdf
[6] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf and https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

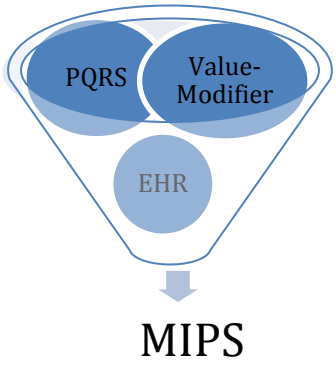
IV. MORE ON MIPS

As part of a broader effort to orient Medicare physician reimbursement more toward value and quality, MACRA alters existing Medicare physician payment reform initiatives in a number of ways, including two integral ones. First, for Medicare FFS reimbursement, the bill streamlines certain existing Medicare quality initiatives into a unified MIPS. In addition, the bill provides for bonus payments to physicians who receive a "significant share" of their revenue through an APM.

With respect to MIPS, MACRA consolidates three of CMS' physician quality and value programs into a unified program (see Figure 2):

1. The Physician Quality Reporting System (PQRS), which incentivizes professionals to report on quality of care measures through a combination of incentive payments and negative payment adjustments;[7]
2. The Value-Based Modifier (VBM) Program, which adjusts payment based on performance on PQRS quality measures (and Medicare cost data), though the value modifier (VM) is a separate adjustment from the PQRS payment adjustment;[8] and
3. 'Meaningful Use' of electronic health records (EHRs) (EHR MU), which stipulates certain requirements in the use of certified EHR systems.[9]

Figure 2: MIPS: Streamlining Medicare Physician Quality and Value Programs



The above programs (and their associated payment implications) will sunset on December 31, 2018, with the MIPS program commencing on January 1, 2019. MIPS will initially apply (in CYs 2019 and 2020) to EPs (individual, group, or virtual groups) consisting of: physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists, and certified registered nurse anesthetists (CRNAs), and groups that include such professionals. However, beginning in 2021 and each year thereafter, the Department of Health & Human Services (HHS) has discretion to include additional EPs. Certain participation exclusions are stipulated, such as qualifying APM participants (or partially qualifying APM participants), or those not exceeding the low-volume threshold measurement.

[7] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/
[8] https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html
[9] https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

A. Composite Performance Scores

Beginning in CY 2019, Medicare payments will be adjusted based on provider performance in the MIPS, rather than the above-referenced individual quality and value programs. CMS must establish through rulemaking by November 1 of each year a list of MIPS quality measures. In general, MIPS quality measures will focus on the following domains: clinical care; safety; care coordination; patient and caregiver experience; and population health and prevention. EPs will be assessed in four performance categories (with some Secretarial discretion to adjust weights), namely:

- Quality (using measures from existing quality programs and new ones developed by professional organizations) – 30% of score;
- Resource use, using measures developed by the current VBM program – 30% of score;
- EHR 'meaningful use' (using requirements established under current regulation) – 25% of score; and
- Clinical practice improvement activities, a new Secretarial-defined component that must account for certain statutorily-stipulated subcategories (i.e., expanded practice access; population management; care coordination; beneficiary engagement; patient safety and practice assessment; and participation in an APM) – 15% of score.

EPs will receive a "composite performance score" based on their performance in each of the above categories (based only on those categories and measures applicable to them). EPs will then be subject to a payment adjustment (positive, negative, or zero) based on their composite performance score (0-100). EPs will know the target score they must attain to avoid a negative adjustment prior to each performance period commencing.

B. Payment Adjustment Factor

Using MIPS composite performance scores, EPs will receive positive, negative or neutral (0%) payment adjustments, depending on whether they fall above, below, or at a given performance threshold (a mean or median of composite scores during a prior period), respectively. CMS will apply a scaling factor to ensure that positive adjustments are budget neutral. The applicable MIPS adjustment factor (positive or negative) is as follows (Figure 3):

Figure 3: MIPS Maximum Payment Adjustments (Upward/Downward)

CY 2019	CY 2020	CY 2021	CY 2022 and thereafter
+/- 4%	+/- 5%	+/- 7%	+/- 9%

Note that MACRA also provides additional incentives to EPs meeting exceptional performance thresholds, appropriating up to $500 million annually over the CY 2019-2024 period for this purpose.

V. MIPS IMPLEMENTATION UPDATE

A. CY 16 MEDICARE PHYSICIAN FEE SCHEDULE RULE

In its CY 2016 MPFS proposed rule issued last July,[10] CMS solicited feedback on MACRA reforms, including MIPS and APMs. For MIPS, CMS was specifically interested in comments on the "low-volume threshold" for EPs, a threshold that, if unmet by the provider, excludes them from MIPS requirements. MACRA authorizes the Secretary to define the low-volume threshold based on: 1) the amount of patients treated; 2) the amount of services rendered; and 3) the amount of charges billed for services, or a combination of these factors. CMS sought feedback on how it ought to define the threshold, and whether it should apply existing low-volume thresholds currently used in other Medicare quality reporting programs.

CMS also sought comment on the scope of "clinical practice activities," a new component of the overall composite score discussed above. Although the clinical practice activity component has statutorily-defined parameters, CMS questioned the extent to which certain activities, within the broader statutory sub-categories, should be included in the definition. In addition, CMS solicited feedback on the APM track which, again, will be discussed in a future TRP issue brief.

While the subsequent CY 2016 MPFS final rule issued last November[11] did not explicitly address the feedback CMS received on MIPS and APMs in its initial proposal, CMS indicated it would consider the comments (and comments related to the above-referenced RFIs) in future rulemaking.

B. MACRA RFI

On September 28, 2015, CMS released a Request for Information (RFI)[12] on the physician payment reform provisions within the MACRA. CMS noted that feedback on the RFI, as well as the 2016 Medicare Physician Fee Schedule (MPFS) rule (see below), will inform its eventual proposed MIPS policies. Comments on the RFI (pursuant to an extension) were due on November 17, 2015.[13]

The RFI delineated a number of specific areas on which input is sought with respect to MIPS, as well as policy considerations for APMs and physician-focused payment models (PFPMs). Regarding MIPS, CMS sought feedback on a number of aspects of the program, including: (1) the specific identifier(s) that should be used to appropriately identify MIPS EPs for purposes of

[10] https://www.federalregister.gov/articles/2015/07/15/2015-16875/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#h-268
[11] https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-28005.pdf
[12] http://www.gpo.gov/fdsys/pkg/FR-2015-10-01/pdf/2015-24906.pdf and https://innovation.cms.gov/Files/x/macra-faq.pdf
[13] http://www.gpo.gov/fdsys/pkg/FR-2015-10-20/pdf/2015-26568.pdf

determining eligibility, participation, and performance under the MIPS performance categories; (2) the parameters that ought to be established for the participation of virtual groups; and (3) the reporting mechanisms that should be available by quality performance category.

C. MACRA Episode Groups Solicitation

On November 10, 2015, CMS issued a solicitation requesting comment on MACRA episode groups, including the process and methodology used to develop episode groups for use in resource use measurement.[14] CMS noted that its development of MACRA episode groups was informed by its work per the Affordable Care Act (ACA) mandate (sec. 3003). This provision of the ACA called for the development of an episode grouper that combines separate but clinically related items and services into an episode of care for use in comparing the patterns of resource use of physicians.[15]

CMS' solicitation reflected episode groups, constructed based on various methods and representing the most costly and prevalent Medicare FFS conditions and procedures. Clinical groupings included episodes related to: breast; cardiovascular; cerebrovascular; gastrointestinal; genitourinary; infectious disease; metabolic; neurology; ophthalmology; musculoskeletal; respiratory; and vascular. CMS seeks feedback on these episode groups, as well as specific questions related to the episode groups, by February 15, 2016. CMS intends to separately post a draft list of patient categories and codes by April 16, 2016. See Appendix A for key dates in this and the broader MIPS process.

D. MACRA Draft Quality Measure Development Plan

On December 18, 2015, as part of the upcoming consolidation of the clinician reporting and incentive programs into the MIPS, CMS released a draft Quality and Measure Development Plan ("draft plan").[16] The draft plan is meant to provide a strategic framework for the agency as it develops future quality measures to support MIPS and APMs.

For MIPS, CMS notes that it will expand upon and harmonize measures in existing programs as well as develop new (de novo) measures according to priorities established under MACRA. These priorities include communication and coordination across measure developers, the use of clinical guidelines in measure development, and categorization of measures across six quality domains – namely: (1) clinical care; (2) safety; (3) care coordination; (4) patient and caregiver experience; (5) population health and prevention; and (6) efficiency and cost reduction. The plan will also identify additional priorities and performance gaps.

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[14] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Episode-groups-summary.pdf
[15] https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
[16] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Draft-CMS-Quality-Measure-Development-Plan-MDP.pdf

In the draft plan, CMS says it will draw from a "strong foundation" in the development and use of quality measures for the PQRS, VM, Medicare EHR Incentive Program and other programs. For measures developed for MIPS, CMS will use the rulemaking process to establish an annual list of MIPS quality measures. This list will include existing measures from the PQRS, VM, and the Medicare EHR Incentive Program. CMS will use the annual 'Call for Measures' process to request that stakeholders identify and submit measures to be considered for selection and to update the annual list of quality measures. The additional measures will be developed using funding provided by MACRA. The draft plan, which is open for comment through March 1, 2016, is expected to be finalized in May 2016.

VI. CONCLUSION

Though MIPS does not begin until January 1, 2019, CMS has already begun to lay the groundwork for the program, including through recent MPFS rulemaking as well as via the solicitation of stakeholder feedback. CMS intends to outline the initial MIPS policies in the forthcoming CY 2017 MPFS proposed rule, due on or around June 30, 2016. However, there are a number of statutorily-stipulated deadlines that CMS must meet in advance of formal MIPS rulemaking, as well as prior to the first MIPS performance year, as indicated in our opening section.

Please see Appendix A for a list of some of the key dates in the transition to MIPS. There is likely to also be ample provider outreach and education – via continued webinars, the issuance of FAQs, and other guidance – to assist clinicians and others in transitioning to MIPS and subsequently to APMs. As always, TRP will continue to keep you apprised of these key developments.

Appendix A: Key Dates in the Transition to MIPS[17]

(This list is not exhaustive and denotes dates only through January 1, 2019, the start of MIPS)

December 18, 2015	CMS posted a Draft Plan for the development of quality measures for MIPS and APMs (comments due: March 1, 2016).
February 15, 2016	The date by which comments are due on CMS' November 10, 2015 solicitation requesting feedback on MACRA care episode and patient condition groups and codes. These episode groups are being established to measure resource use for MIPS and APMs.
March 1, 2016	The date by which comments are due on the above-referenced Draft Plan for the development of quality measures for MIPS and APMs.
Spring (March) 2016	CMS' target date for the release of a proposed rule (CMS-5517-P) titled, "Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) in Medicare Fee-for-Service." This rule is likely to address the "release of criteria for publicly submitted physician-focused payment models [PFPMs] and…the…MIPS quality measures list."
April 16, 2016	The date by which CMS intends to post a draft list of MACRA patient categories and codes (for which comments will likely be due August 13, 2016).
May 1, 2016	CMS intends to post the Final Plan for the development of quality measures for MIPS and APMs. CMS notes that the plan will "address how measures used by private payers and integrated delivery systems should be incorporated" and will "take into account how clinical best practices and guidelines should be used in measure development."
Summer 2016	CMS intends to propose initial MIPS policies via the CY 2017 MPFS proposed rule (CMS-1654-P).
July 1, 2016	The date by which HHS must issue a report to Congress examining the feasibility of integrating APMs in the Medicare Advantage (MA) payment system.
August 13, 2016	The date by which comments will likely be due on the above-referenced draft list of MACRA patient categories and codes.
Fall 2016	CMS slated to finalize (or partially finalize) initial MIPS policies, likely via the CY 2017 MPFS final rule (due by November 1).
November 1, 2016	The statutory date by which HHS must, through notice and comment rulemaking and following a RFI, establish criteria for PFPMs and release the annual MIPS quality measures list. See above.

[17] In general, key dates derived explicitly the MACRA statute and/or via HHS guidance (e.g., http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf; https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf; and https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Episode-groups-summary.pdf). Dates also informed via HHS Semi-annual Regulatory Agenda (Fall 2015 ed.).

November 16, 2016	The approximate date (i.e., 18 months upon MACRA's enactment) by which the GAO is required to issue a report to Congress examining the alignment of quality measures in public and private programs. (Note: additional evaluative reports stipulated of the GAO in 2021).
January 1, 2017	GAO to issue a report examining whether entities that pool financial risk for physician practices (e.g., independent risk managers) can play a role in supporting physician practices in assuming financial risk for treating patients. (Note: additional evaluative reports stipulated of the GAO in 2021).
May 1, 2017 (and annually thereafter)	Requires HHS to post on the CMS website a report on the progress made in developing quality measures to assess professionals.
July 1, 2017	CMS must make available timely confidential feedback reports to each MIPS EP.
July 1, 2017	MedPAC's initial report to Congress due on the relationship between: (1) physician and other health professional utilization and expenditures (and their rate of increase) of items and services for which Medicare payment is made; and (2) total utilization and expenditures (and their rate of increase) under Medicare Parts A, B and D. (Note: Separate report dues by July 1, 2019 and July 1, 2021).
April 16, 2018	The date by which HHS, in consultation with the Office of Inspector General (OIG) must issue a report on fraud related to Medicare APMs.
July 1, 2018	CMS must make available to EPs information about items and services furnished to the EP's patients by *other* Medicare providers and suppliers.
November 1, 2018 (and each year thereafter for applicable performance years)	HHS must, through notice and comment rulemaking, establish the list of quality measures for which MIPS EPs may choose for purposes of an assessment for the CY 2019 performance year. Note also that this is the deadline for the first of a number of annual updates pertaining to care episodes and patient condition groups and codes, as well as patient relationship categories and codes.
December 31, 2018	Payment adjustments under PQRS, VM, and EHR-MU officially sunset in advance of upcoming MIPS.
January 1, 2019	First year of MIPS and APM incentive payments.