Congress passed and the President signed into law H.R. 2, “The Medicare Access and CHIP Reauthorization Act” (MACRA) which permanently repealed the Sustainable Growth Rate (SGR) formula and included the establishment of the Merit-Based Incentive Payment System (MIPS).

The current scheme of penalties under the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU) and the Value-Based Payment Modifier (VBM) will end at the close of 2018.

**MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS):**

In 2019, the MIPS program will become the only Medicare quality reporting program.

Performance under the MIPS will be based on 4 categories including: quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities. Weights are assigned to each category to create a total composite score of 0-100 for physicians based on their performance in these categories:

**Quality Measures:** (30%) based on those in existing measurement programs and other potential measure eligibility pathways.

**Resource Use:** (30%) Largely based on the current Value-Based Payment Modifier system.

**Meaningful Use:** (25%) Largely based on the current Meaningful Use Program, and;

**Clinical Practice Improvement Activities:** (15%) Activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary of HHS determines, when effectively executed, is likely to result in improved outcomes.

Physicians will be encouraged to report quality measures through certified EHR technology or qualified clinical data registries. Participation in a qualified clinical data registry will also count as a clinical practice improvement activity.

**ASSISTANCE FOR SMALL PRACTICES:**

$20 million per year, from fiscal years 2016 through 2020, will assist practices of up to 15 professionals to participate in the MIPS program or transition to new payment models. Small practices (up to 10 MIPS-eligible professionals) can also elect to report together as virtual groups and receive a MIPS composite score for their combined performance.
DUAL TRACK PAYMENT SYSTEM:

H.R. 2 establishes a dual track payment system for physicians. The Merit based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

The three components of the current value based payment system will be combined into one MIPS score using elements of PQRS, Value Based Modifier and Meaningful Use. The blended score will determine a mean above which bonus payments are possible and below which penalties will be assessed.

If participating in an Alternative Payment Model (APM) the physician cannot participate in MIPS. The larger potential rewards are in APMs.

QUALITY MEASURES:

MIPS builds and improves upon the current quality measures and concepts in PQRS, Meaningful Use and Value-Based Payment Modifier.

Every year the Secretary will publish a list of quality measures to be used in the forthcoming MIPS performance period. Updates and modifications to the list of quality measures will also occur through this process. Eligible professionals will select which measures on the final list to report and be assessed on.

Eligible professional organizations and other relevant stakeholders will identify and submit quality measures to be considered for selection and to identify and submit updates to the measures already on the list. Any measure selected for inclusion that is not endorsed by a consensus-based entity e.g. National Quality Forum (NQF) must be evidence-based.

Before including a new measure in the final list, the Secretary will submit the measure for publication in an applicable specialty-appropriate peer-reviewed journal, including the method for developing and selecting the measure.

Qualified clinical data registries and existing quality measures will NOT be subject to these additional requirements and will be automatically included in the first program year’s final list of quality measures. These measures will remain in the MIPS Program unless they are removed under the rulemaking process.
THRESHOLD ISSUE:

This new version of physician value-based purchasing for the period 2019 to 2025 will be based on a provider’s score in 4 areas:

Quality measures;
Efficiency measures;
Meaningful Use of Electronic Health Records, and;
Clinical Practice Improvement Activities.

Providers will receive a composite score of 1-100 based on their performance on the measures. Each year, CMS will establish a threshold score based on the median or mean composite performance scores of all providers measured during the previous performance period. The threshold will be published at the beginning of each year, in advance of the performance period to be measured.

Providers scoring above the threshold will receive bonus payments. Those providers with higher performance scores will receive proportionately larger payments.

Providers scoring below the threshold will be subject to payment reductions. These negative payment adjustments will be capped at:

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-4%</td>
</tr>
<tr>
<td>2020</td>
<td>-5%</td>
</tr>
<tr>
<td>2021</td>
<td>-7%</td>
</tr>
<tr>
<td>2022</td>
<td>-9%</td>
</tr>
</tbody>
</table>

Unlike current law, the MIPS penalties provide greater certainty and have a maximum range in future years.

BUDGET NEUTRALITY: Payments provided for those scoring above the threshold will be funded by the penalties assessed against providers scoring below the threshold. Performance scoring under the MIPS program has some advantages over the current quality programs:

The MIPS does not employ the Value Based Modifier threshold model, which requires both winners and losers, thereby potentially penalizing even high performing physicians since someone has to be a loser. In the MIPS, if all physicians perform at or above the performance threshold, no one will get a penalty.

Performance assessment under the MIPS program will be according to a “sliding scale” – versus the current “all or nothing” approaches used in PQRS and Meaningful Use. Credit will be provided to those who partially meet the performance metrics.
At the start of each performance period, physicians will know the threshold score for successful performance.

**$500 MILLION EXTRA PER YEAR:**

Additional funding is provided for exceptional performance, up to $500 million per year, from 2019 through 2024.

**PAYMENT UPDATES:**

Updates of 0.5% are provided for 5 years, from 2015 to 2019. (Starts July 1, 2015)

Rates in 2019 maintained through 2025, while providing opportunities to receive additional payment adjustments through MIPS or APMs.

In 2026 and subsequent years, professionals participating in Alternate Payment Models (APMs) that meet certain criteria will receive annual updates of 0.75%, while all other professionals will receive annual updates of 0.25%.

**ENCOURAGING PARTICIPATION IN ALTERNATE PAYMENT MODELS (APMs):**

The Department of Health and Human Services (HHS) has set a goal of 30% of traditional fee for service (FFS) payments to quality and/or value through APM by 2017. Further the goal is 50% of FFS by 2018. These APMs include bundled payment initiatives (BPI) and Accountable Care Organizations (ACO). This will pressure physicians to work in larger groups where the cost of electronic health records (EHRs) and quality reporting becomes more efficient compared to individual reporting.

**APM BONUS:**

To encourage physicians to participate in APMs and to help offset investments or other costs they may incur, the law provides 5% bonus payments from 2019-2024 for those who join new Alternative Payment Models (APMs).

Professionals who receive a significant share of their revenues through an APM(s) that involves risk of financial losses and a quality measurement component will receive a 5% bonus each year from 2019-2024. These bonuses are larger than what is available in MIPS and a physician cannot participate in both MIPS and APMs.

For the 2019 and 2020 payment years, at least 25% of the physician’s Medicare reimbursement during the most recent period for which data are available must have been provided through an eligible APM entity, such as a Medicare Shared Savings Program Accountable Care Organization (ACO). For the 2021 and 2022 payment years, a physician may qualify for the APM incentive if the APM share of Medicare
reimbursement is at least 50% through eligible APM entities. The 50% threshold rises to 75% for 2023 and subsequent payment years.

**ELECTRONIC HEALTH RECORDS:**

MACRA sets a goal of achieving “widespread interoperability” nationwide of Electronic Health Record (EHR) systems (across certified EHR systems employed by meaningful users, clinicians, and other health providers) by December 31, 2018. By July 1, 2016, the Secretary of HHS must establish, in consultation with stakeholders, the metrics to determine if this goal has been achieved. Information blocking by MU professionals and hospitals is prohibited, effective April 16, 2016.

**WHEN CONSIDERING MACRA IT IS IMPORTANT TO REMEMBER WHAT THE PREVIOUS LAW WAS:**

*Without MACRA, on March 31st SGR cuts of 21% would have gone into effect.*

**CMS is shifting the basis for Medicare payments from volume to value.**

January 26, 2015: HHS Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

**The following quality programs are in effect NOW:**

**Physician Quality Reporting System (PQRS):**


**Meaningful Use:**

*(Penalty: 2015: -1% to -2%; 2016: -2%; 2017: -3%; 2018: - 4%; 2019 and beyond: -5%)* “Meaningful Use” means providers need to show they’re using certified electronic health records (EHR) technology in ways that can be measured significantly in quality and quantity.

The American Recovery and Reinvestment Act of 2009 specify 3 main components of Meaningful Use:

- The use of a certified Electronic Health Record (EHR) in a meaningful manner;
- The electronic exchange of health information to improve quality of health care;
- The use of certified EHR technology to submit clinical quality and other measures.
After 2015, Medicare will require that all Medicare eligible professionals and hospitals meet meaningful use or they will be subject to a financial penalty.

**Value-Based Payment Modifier:**

(Penalty: 2015: -1%, applied to groups of 100 or more/2013 data; 2016: -2% groups of 10 or more/2014 data; 2017: -4% for groups of 10 or more, -2% for solo and small groups/2015 data; 2018: (?) all physicians/2016 data; 2019 (?) all physicians /2017 data).

Section 3007 of the Affordable Care Act mandated that by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS). Both cost and quality data are to be included in calculating payments for physicians.

Physicians in group practices of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number will be subject to the value modifier in 2015, based on their performance in calendar year 2013.

Physicians in group practices of 10 or more eligible professionals who participate in Fee-For-Service Medicare under a single tax identification number will be subject to the value modifier in 2016, based on their performance in calendar year 2014.

All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017.

For each payment adjustment year, physician groups ranked into one of three rewarded cost/quality tiers will have their Medicare payments increased. Conversely, certain adjustments will be applied to Medicare physician payments to physician groups that are categorized in one of the program’s three cost/quality tiers as receiving a downward payment adjustment. This categorization is based on data from the performance period (e.g. 2013 for the 2015 payment adjustment year).

**VALUE BASED MODIFIER (VBM) BUDGET NEUTRALITY:**

The Value Based Modifier Program is budget neutral: The projected aggregate amount by which payments will increase for some groups of physicians based on high performance must be equal to the projected aggregate amount by which payments will decrease for others based on low performance or failure to meet the minimum quality reporting requirements for the Value Modifier.
2017 marks the third year that the VBM will be applied; the magnitude of the adjustments that will be made in future years is determined through annual rulemaking. Since the adjustments have doubled each year since the VBM was first implemented, the potential for increasingly severe cuts in 2018 and beyond is significant. Some physicians will qualify for payment bonuses of an amount not yet known.

<table>
<thead>
<tr>
<th>Year</th>
<th>Meaningful Use</th>
<th>PQR S</th>
<th>VBM (Budget Neutral)</th>
<th>TOTAL CURRENT LAW (NO INCR FUNDING NOR UPDATES)</th>
<th>H.R. 1470/S 810: SGR REPEAL</th>
<th>+UPDATES SGR REPEAL</th>
<th>FUNDING SGR REPEAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>-1% to -2%</td>
<td>-1.5%</td>
<td>±1% Applied to groups of 100 or more / 2013 data</td>
<td>-4.5% -4.5%</td>
<td>+0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>-2%</td>
<td>-2%</td>
<td>±2% groups of 10 or more / 2014 data</td>
<td>-6% -6%</td>
<td>+0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>-3%</td>
<td>-2%</td>
<td>±4% for groups of 10 or more, -2% for solo and small groups / 2015 data</td>
<td>-9% to +9%</td>
<td>+0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>-4%</td>
<td>-2%</td>
<td>±4% all physicians / 2016 data</td>
<td>-10% to 10%</td>
<td>+0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>-5%</td>
<td>-2%</td>
<td>±4% all physicians / 2017 data</td>
<td>-11% to ±11% (SUNSETTED BY SGR REPEAL)</td>
<td>-4% - 4%</td>
<td>+0.5% (+2.5% OVER 5YRS)</td>
<td>500 Mill</td>
</tr>
<tr>
<td>2020</td>
<td>-5%</td>
<td>-2%</td>
<td>±4% all physicians / 2017 data</td>
<td>-11% to +11% (SUNSETTED)</td>
<td>-5% - 5%</td>
<td>0%</td>
<td>500 Mill</td>
</tr>
<tr>
<td>2021</td>
<td>-5%</td>
<td>-2%</td>
<td>±4% all physicians / 2017 data</td>
<td>-11% to +11% (SUNSETTED)</td>
<td>-7% -7%</td>
<td>0%</td>
<td>500 Mill</td>
</tr>
<tr>
<td>2022</td>
<td>-5%</td>
<td>-2%</td>
<td>±4% all physicians / 2017 data</td>
<td>-11% to +11% (SUNSETTED)</td>
<td>-9% -9%</td>
<td>0%</td>
<td>500 Mill</td>
</tr>
<tr>
<td>2023</td>
<td>-5%</td>
<td>-2%</td>
<td>±4% all physicians / 2017 data</td>
<td>-11% to +11% (SUNSETTED)</td>
<td>-9% -9%</td>
<td>0%</td>
<td>500 Mill</td>
</tr>
<tr>
<td>2024</td>
<td>-5%</td>
<td>-2%</td>
<td>±4% all physicians / 2017 data</td>
<td>-11% to +11% (SUNSETTED)</td>
<td>-9% -9%</td>
<td>0%</td>
<td>500 Mill</td>
</tr>
</tbody>
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** 2017 marks the third year that the VBM will be applied; the magnitude of the adjustments that will be made in future years is determined through annual rulemaking. Since the adjustments have doubled each year since the VBM was first implemented, the potential for increasingly severe cuts in 2018 and beyond is significant. Some physicians will qualify for payment bonuses of an amount not yet known.**