Good-Bye SGR, Hello MACRA and MIPS

Apparently, the 18th time’s the charm. Late in the evening of April 14, the U.S. Senate voted 92-8 in favor of passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Among many other things, this legislation permanently repeals the sustainable growth rate (SGR) formula. President Obama has promised to sign MACRA into law when it arrives on his desk.

As a result, payments under the Medicare Physician Fee Schedule (MPFS) for services furnished on or after April 1 will not be cut by 21%. Instead, current payment rates will remain in place until June 1, at which point they will be increased by 0.5%.

The MPFS rates then will be increased by 0.5% in 2016, 2017, 2018, and 2019. The rates will remain constant at the 2019 rates through 2025.

During that same period, 2019 to 2025, providers will have the opportunity to earn bonus payments – or be subject to stiff penalties – under the new Merit-Based Incentive Payment System, or MIPS (more on MIPS below).

After 2025, MPFS rates will be updated annually by 0.5%. However, providers who participate in approved alternative payment models (more on APMs below), will receive an additional 0.5% increase, earning a total annual increase of 1.0%.

Under MACRA, the Medicare Advisory Payment Commission (MedPAC) is required to study and make regular reports to Congress regarding the impact of MPFS rate adjustments on beneficiary access and quality of care. Based on this information, Congress can determine whether additional increases are warranted.

MIPS

Through the end of 2018, providers will continue to be subject to the penalties associated with the Physician Quality Reporting System (PQRS), the meaningful use program, and the physician value-based purchasing program. You can learn more about those programs here.

Beginning in 2019, these programs will be replaced by MIPS. This new version of physician value-based purchasing will be based on a provider’s composite score across four domains: (1) quality measures; (2) efficiency measures (i.e., controls on total cost of care); (3) meaningful use of electronic health records; and (4) clinical practice improvement activities.
The Centers for Medicare & Medicaid Services (CMS) is charged with defining measures for each domain, subject to certain requirements. For example, MACRA imposes specific requirements regarding the selection of quality measures and identifies specific types of clinical practice improvement activities, such as the use of remote patient monitoring.

Providers will receive a composite performance score from 1 to 100 based on their performance on the to-be-specifically-defined measures. **These scores will be reported publicly**, meaning everyone will be able to look up a provider’s score. Providers whose scores improve year-to-year will receive extra credit, as a way to incentivize performance improvement.

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 below the threshold will be subject to payment reductions. These negative payment adjustments will be capped at -4% in 2019, -5% in 2020, -7% in 2021, and -9% in 2022.

Providers scoring above the threshold will receive MIPS bonus payments. Those providers with higher performance scores will receive proportionately larger payments, bonuses of up to three times the annual penalty cap (i.e. up to a 12% increase in 2019.) These bonus payments will be funded by the penalties assessed against providers scoring below the threshold.

In addition, the best-of-the-best – those who score above a “stretch” performance score established by CMS – will receive an additional bonus payment allocated from a $500 million pool to be funded annually. These additional incentive payments will be allocated according to a linear distribution, with better performers receiving larger bonuses.

**APMs**

Providers who receive a significant percentage of their income through alternative payment mechanisms (APMs) that involve risk of financial losses and quality reporting requirements will have the option to opt out of MIPS, and instead receive an annual 5% bonus payment between 2019 and 2024. Again, the legislation provides broad outlines, leaving it to CMS to define exactly what qualifies as an APM and what amounts to a significant percentage of income.

To ensure all providers have the opportunity to participate in MIPS, MACRA directs CMS to perform testing of APMs relevant to specialty professionals, professionals in small practices, and those that align with private and state-based payer initiatives. Further, a Technical Advisory Committee will be established to consider physician-focused APM proposals. CMS also is required to identify and address potential fraud vulnerabilities in APMs.

MACRA specifically provides that any standard established under any federal healthcare program cannot be used in a medical malpractice case as evidence of a standard or duty-of-care owed by a provider to a patient. Thus, MIPS participation cannot be used in liability cases.

In addition to these fundamental changes to the way in which physicians and other providers are paid by Medicare, MACRA also requires that electronic health records (EHR) be interoperable by 2018 and prohibits providers from deliberately blocking information sharing with other EHR vendor products. This mandate – which will eliminate the most significant barrier to electronic health
information exchange - may very well prove to be just as important as new value-based payment models in driving the transition to population health management.

There are many more important provisions contained in MACRA’s 300 pages. While we may celebrate the demise of the SGR today, we now must prepare for new payment and delivery models. The transition from volume-based reimbursement to value-based payments is now defined by law.