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SGR Law Creates Merit-based Incentive Payment System and Incentives for Alternative Payment Model Participation

U.S. Health Care Alert

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The Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA” or the “Act”),¹ signed into law by President Barack Obama on April 16, has been touted as one of the most significant Medicare payment reforms in decades, with the “potential to have a bigger impact on the American health-care financing system than Obamacare.”² K&L Gates has previously published *Client Alerts* on [changes to the Gainsharing CMP](#) and on [changes to the Recovery Audit Contractor Program](#). This *Client Alert* focuses on changes to the Medicare physician reimbursement model ushered in by the new law.

MACRA repealed the widely unpopular sustainable growth rate methodology (“SGR”), narrowly averting a scheduled 21% cut in the Medicare Physician Fee Schedule (“PFS”) and ending a perennial debate over the Medicare fee structure for physician reimbursement. It introduced more predictable annual payment updates, which are subject to modification based on participation in certain alternative payment models (“APM”), and established a performance-based payment structure, known as the Merit-based Incentive Payment System (“MIPS”). MACRA is another step away from traditional fee-for-service reimbursement, and reflects the government’s continued commitment to risk-sharing payment models that incentivize cost savings and quality improvement.

Reimbursement Formula Updates

In addition to repealing the SGR, Section 101 of the Act provides for more stable updates to Medicare payment rates. Between 2015 and 2025, there will be a single conversion factor applied to payment rates under the Medicare PFS, with the potential for additional adjustments through the MIPS program (see below). Beginning in 2026, there will be two conversion factors: one for qualifying APM participants and one for eligible professionals not participating in a qualifying APM. The updated annual conversion factors will be:

- January–June, 2015 0.0%;
- July–December, 2015 0.5%;
- 2016–2019 0.5%;
- 2020–2025 0.0% (see alternative incentive structures below); and

¹ “Medicare Access and CHIP Reauthorization Act of 2015,” H.R. 2, 114th Cong. (2015) (enacted) (to be codified in scattered sections of 16 and 42 U.S.C.).

² Sara Hansard, *Medicare Sustainable Growth Rate Repeal Bigger Than Obamacare*, Bloomberg BNA (April 20, 2015), <http://www.bna.com/medicare-sustainable-growth-b17179925406>.

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- 2026 and subsequent 0.75% for Qualifying APM participants
0.25% for MIPS-eligible professionals

The Merit-Based Incentive System

MACRA replaces three existing Medicare incentive programs—the Electronic Health Record Meaningful Use program (“MU”), the Physician Quality Reporting System (“PQRS”), and the Value Based Payment Modifier program (“VBM”)—consolidating them under a single umbrella. Each of these independent programs will sunset in 2018 and will be reformed under MIPS starting January 1, 2019. In 2019 and 2020, MIPS eligibility will be limited to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and clinical registered nurse anesthetists that do not participate in APMs. After 2021, eligibility may be expanded at the discretion of the Secretary of Health and Human Services.

MIPS Scoring: MIPS-eligible professionals will receive a composite performance score of 0-100 based on four performance components:

- *Quality measures* (30%) that must include measures in the following key areas: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. The Secretary is directed to establish an annual list of quality measures for purposes of assessment during a given performance period no later than November 1st of the preceding year, and may only approve measures subjected to peer review, endorsed by a professional organization, or are evidence based. A draft quality measure development plan must be published by January 1, 2016 and finalized by May 1, 2016 following a notice and comment period.
- *Resource use* (30%) will initially incorporate the total cost of care measures in the current VBM program. The Secretary is also directed to develop new classification codes related to care episode groups, patient condition groups, and patient relationship categories and codes, which will be used to develop new measures related to the impact of providers on overall resource use in patient care. Eligible professionals will be required to include these new codes on claims as applicable beginning January 1, 2018.
- *Meaningful use of electronic health records requirements* (25%) will be substantially similar to the current MU program, and quality measure reporting under MIPS will automatically satisfy MU reporting requirements in order to eliminate any inconsistencies between the MU and MIPS requirements.
- *Clinical practice improvement activities* (15%) identified as improving clinical practice or care delivery that are likely to result in improved outcomes when properly executed will be established by the Secretary, and eligible professionals will receive credit for engaging in such activities. CPIAs must include activities in the following subcategories: expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in APM models.

MIPS-Based Payment Adjustments: In 2017 and 2018, CMS will provide eligible professionals with performance feedback on certain MIPS measures, such as quality and resource use allocation. Beginning in 2019, MIPS payment adjustments will be based on

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eligible professionals' composite performance score relative to an annual performance threshold based on either the mean or the median (selected by the Secretary every three years) of the composite performance scores for all MIPS-eligible professionals in a prior period, and will be made available at the beginning of the performance period so that eligible professionals will know the composite score they must achieve to obtain incentives and avoid penalties.³

Eligible professionals who meet or exceed the threshold will receive either no payment adjustment or a positive payment adjustment, respectively. Further, between 2019 and 2024, the Act allocates an additional \$500 million per year to be distributed to MIPS-eligible professionals who demonstrate exceptional performance by meeting or exceeding an additional performance threshold set by the Secretary as additional bonus payments.

Eligible professionals who fall below the performance threshold will receive a negative adjustment. Downward adjustments are capped, with the worst performers—those who score between zero and one-quarter of the performance threshold—receiving payment reductions of:

- 4% in 2019;
- 5% in 2020;
- 7% in 2021; and
- 9% in 2022 and beyond.

Incentive Payments for Participation in Alternative Payment Models

The Act allows qualifying APM participants to opt out of MIPS assessments and most MU requirements, and contains additional incentive payments for eligible professionals who receive a certain significant share of their revenue through “qualifying APMs” that involve risk of financial loss, report quality measures, and use certified EHR technology.⁴ Between 2019 and 2024, eligible professionals participating in qualifying APMs will receive an annual lump-sum bonus equal to 5% of the estimated aggregate PFS payments the preceding year, and an additional 0.5% annual update beginning in 2026.

Conclusions

MACRA's import goes well beyond repealing the SGR: the Act's Medicare payment reforms signal the government's continued interest in quality and efficiency benchmarking and its commitment to two-sided risk models. Health care providers and institutions should monitor CMS regulations and guidance for information on how the agency will implement MIPS and the new APM incentive payments, including the development of composite scoring criteria and performance thresholds.

³ In the first two years, the Secretary will establish a performance threshold and exceptional performance threshold taking into account existing data related to the MIPS performance score categories.

⁴ Under MACRA, an APM is one of the following: a CMS Innovation model (except the healthcare innovation award); the Shared Savings Program; the Healthcare Quality Demonstration Program; or another demonstration required by federal law. Eligible professionals participating in a patient-centered medical home APM that meets certain criteria are not subject to the downside risk requirement.

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