



# The Physicians Foundation “Medicare Watch List” Report

**Slaying the SGR Dragon**  
**Victory is Sweet, but Hardball Future for Physicians?**



June 2015



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### **Prepared by:**

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and

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### **Prepared on Behalf of**

THE PHYSICIANS FOUNDATION

To empower physicians to lead in the delivery of high-quality, cost-efficient healthcare

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The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and help facilitate the delivery of healthcare to patients. It pursues its mission through a variety of activities including grantmaking, research, white papers and policy studies. Since 2005, The Foundation has awarded numerous multi-year grants totaling nearly \$36 million. In addition, The Foundation focuses on the following core areas: physician leadership, physician practice trends, physician shortage issues, and the impact of healthcare reform on physicians and patients. As the healthcare system in America continues to evolve, The Physicians Foundation is steadfast in its determination to strengthen the physician-patient relationship and assist physicians in sustaining their medical practices in today’s practice environment.

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## Pocket Watch List and Action Venues

1. **WATCH: Fiscal actions' individual and cumulative impact on aggregate payment adequacy for medical items and services**
  - a. Effects of 2015 and outyear PFS conversion factor freezes and specified updates.
  - b. Proportion of services paid under MIPS v. APMs; crucial outyears trajectory.
  - c. Regulatory actions on methodologies for calculating key payment model elements with high payment level impact potential: e.g., composite scores, weighting of performance categories, performance threshold decision (use of mean or median of composite scores), bonuses, scaling factors and budget neutrality.
  - d. Note: CMS Actuary's adequacy caution re H.R. 2 payment during law passage. Review 2015 Medicare HI and SMI Trustee's Report.
  - e. Payment model components not subject to judicial review.
2. **WATCH: Key payment model(s) building blocks (MIPS/APM)**
  - a. Methodologies for assessing total performance of each MIPS professional in each of 4 categories: Quality, Resource Use, Clinical Practice Improvement Activities, and Meaningful Use of Certified EHR Technology.
  - b. Relative weighting of performance categories, measures and activities for calculating composite performance scores for each professional.
  - c. Methods for use of aggregations of individual composite scores in incentive payments (mean v. median impact of DHHS choice).
  - d. Development of resource use, care episode, patient condition and patient relationship code sets; grouper methodologies for patient classification purposes; methods for determining relative resource use values (charge-based?). Near-term publication deadline.
  - e. Methods for providing confidential feedback on performance to eligible professionals.
  - f. Public posting of physician data (accuracy, form, frequency).
  - g. Under APMs, criteria for physician-focused payment models (11/01/16 publication deadline for rulemaking by DHHS).
3. **ACTION: Major Venues for Action (Regulatory) – 12 to 18 months**
  - a. Participation in DHHS "Physician-Focused Payment Models Technical Advisory Committee" (GAO appointments in 10/15).
  - b. Medicare physician payment and Part B NPRM and final rules for 2016 (likely to reveal initial directions by DHHS).
  - c. Medicare Inpatient Hospital Services rules for 2016, esp. quality.
  - d. Ongoing CMS announcements on ACOs; Medicare Shared Savings Program; other pertinent sub-regulatory opportunities for input.
  - e. GAO and MedPAC due to oversight and mandated reports roles.

# Slaying the Medicare SGR Dragon

## Victory is Sweet, But “Hardball Future” for Physicians?

The medical profession was justified in celebrating this spring’s Congressional action to eliminate the sustainable growth rate (SGR) formula. However, the hard-fought victory, while sweet, comes wrapped with many new challenges regarding the future Medicare payment framework for physicians. On April 16, 2015 the President signed into public law H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). A mere two months later, tough medical practice and payment model questions under future Medicare reforms are emerging.

The Secretary of the federal Department of Health and Human Services has been granted broad discretionary authority over how to define key concepts and requirements for new payment models for physicians and other health professionals. There are extensive payment model changes and processes under MACRA that will impact heavily upon physicians in medical practice. In this “**Medicare Watch List**” report, the Physicians Foundation provides a rapid, early assessment of what some of the toughest issues may be.

In so doing, we focus our scrutiny on top-line physician payment model reform issues as policy development and rulemaking proceeds in the Executive Branch. Our purpose is to highlight central regulatory topics, and related venues for early intervention. Our initial timeline is the next 12-18 months. In our view, the issues we identify require active participation by the medical community to ensure the concerns and contributions of practicing physicians are properly incorporated into regulatory development. Finally, it is important to acknowledge that our partners in health care — other health

professionals, hospitals and more — are also deeply affected by systemic reform changes reflected in MACRA. Those changes are outside the scope of this report, but we note later some areas of direct intersection.

**Part I—Shifting Ground in MACRA for Physicians.** In this section, we discuss context and share observations about the new law. This is a non-partisan take on certain high-stake politics riding alongside the Congress’s actions, and on the reform objectives of the Administration that will shape implementation of the new law.

**Part II—The Physicians Foundation Medicare Watch List.** The Physicians Foundation’s “Medicare Watch List” appears in this section and is divided into three parts: 1) Watch List Topics, 2) Regulatory Implementation Venues, and 3) Special Other Intervention Points, most spanning a 12–18 month timeline. Appendix I provides regulations timelines. Appendix II provides a reference-only summary of important, select changes for physicians in Title I of MACRA that are related to our Watch List topics. In that summary, we also highlight important MACRA provisions not subject to judicial review, meaning that the Congress has removed certain elements of the law from being subject to administrative challenges and judicial review.

**Conclusion.** The Physicians Foundation thanks you for your time and attention. We trust you will find the following sections to be a useful addition to your “armament” regarding the implications of the new provisions of Medicare law.







## Part I ➤ Shifting Ground in MACRA for Physicians

The SGR is out,  
but so is physician  
practice autonomy.

**A Medical Community Perspective.** The sustainable growth rate or SGR formula, enacted under the Balanced Budget Act of 1997, was used to set annual updates to Medicare payments for doctor's services under the physician fee schedule (PFS). Due to details of how the formula worked, scheduled updates increasingly skewed away from annual cost *increases* measured by a separate Medicare Economic Index (MEI) measuring changes in physician practice costs and other economic indicators.

By 2015, the update formula would have led to a stunning 21-plus percent *reduction* in Medicare PFS payment levels to doctors. These disparities were growing as physicians faced unprecedented new costs in medical practice attributable to costly technological changes and data reporting burdens. Many such costs and burdens were either initiated by or were deeply accelerated by provisions enacted under the Patient Protection and Affordable Care Act of 2010 (ACA or "Obamacare"), and other laws.

For nearly two decades, the Congress was faced with difficult decisions over whether to allow the consequences of SGR flaws to go into effect unmitigated. In 17 different legislative actions, the Congress overrode the workings of the formula and instead substituted specified, but short-term, updates to the PFS. Finally, thanks largely to the sustained efforts of physicians and their representative organizations, the Congress voted on and President Obama signed MACRA into public law (P.L. 114-10).

The enactment of MACRA is the harbinger of even deeper systemic changes to come in health care. The baton now passes to the Administration. Without doubt, regulators have difficult public policy responsibilities to execute upon, and we respect their responsibilities. However, the medical community has a shared obligation to ensure patients' health care needs and medical practice realities are reflected in new Medicare rules and requirements.

This law's provisions affirm that it's nearly



impossible for individual physicians to “go it alone” in this complex practice environment. Indeed, the new financial incentives in MACRA for physicians to participate in alternative payment models would explicitly reward collaboration, risk assumption and risk-sharing in the future.

In familiarizing ourselves with MACRA provisions, we were struck by the deeper implications. The tools now required to succeed in medicine increasingly transcend the exceptional educational, financial and practice development costs individual physicians already incur to practice. Simply to meet the regulatory requirements affecting medical practice requires deployment of sophisticated medical, legal, technological and economic resources. For this reason, the Foundation would like to acknowledge the contributions of state medical societies, physicians’ medical associations, and other supportive professionals assisting physicians in navigating health care infrastructure and compliance requirements, and their efforts to reduce burdens placed on medical practice. It’s been a tough road and there are new challenges ahead under MACRA.

For instance, beyond the areas receiving the greatest attention of the physician community, MACRA is a diverse, comprehensive bill that legislated in a number of federal health program areas. It consists of five separate titles and sixty-two sections. The public law print is 95 pages of complex and extremely fine print. Taken in isolation, Title I—SGR Repeal and Medicare Provider Payment Modernization, collectively describes *extensive* new provisions impacting upon physicians and other health professionals participating in the Medicare program. In this changed environment, a little political and policy context is important to a proper consideration of the law.

### **Congressional Doubling-Down on the ACA?**

First, set aside the headline repeal of the SGR and the temporary schedule of annual updates of 0.5 percent to the Medicare physician fee schedule (PFS) through 2019. The real story in MACRA is the much deeper evolution in Congressional and Administration thinking about the ways in which entitlement programs, and

especially Medicare, can or should be leveraged to effect health system changes. The Title I changes affecting physicians exemplify such evolutionary changes in favor of tougher scrutiny, greater accountability and tighter rewards for all health care providers. This shift is occurring through the law’s details and in the Administration’s policy choices to come in implementation. MACRA represents the next stage of a collective public policy drive to “pay for value, not volume.” The goal is to ever more tightly pair payment incentives with quality and outcome performance measures, and to thereby address perceived excess volume and unsatisfactory quality levels in health care services.

Perhaps the heel-rocker for some is that the Republican Majority in the U.S. Congress, with bipartisan support, has effectively endorsed deeply prescriptive health care system (as opposed to insurance coverage expansion) reforms of the ACA and other laws, as they are manifested in the Medicare program. In MACRA, the Congress has advanced significantly many of the ACA’s provider-oriented reform provisions to the next evolutionary stage. For instance, Title I legislates next-generation incentives for medical practice organization and payment models, provider profiling, performance standards, and more. Changes occur in multiple public program areas in MACRA, but we suggest that none eclipse the significance of the Medicare physician payment reform model changes.

MACRA’s enactment suggests that the politics surrounding the original ACA law have become politically bifurcated. The continued Republican efforts to “repeal Obamacare” de-facto exempt Medicare reforms, including higher costs for some beneficiaries, from that effort. In reality, the Republican leadership’s “ACA repeal” efforts appear to be more selectively focused on a large bundle of mandates, taxes, subsidies and other ACA provisions that relate to extending health insurance coverage through federal and state exchanges, and to certain Medicaid program changes.

For example, on June 4, the House Republican Study Committee (a policy, not legislative, group) introduced a draft ACA repeal and

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Early Administration policy approaches and execution on MACRA provisions is paramount, and should be the primary focus of physicians right now.

“Obamacare” replacement plan. While Title I of the draft language would repeal the original 2010 law in its entirety, upon close reading, it is silent on the implications such an action would have on the Medicare program provisions in the original ACA, or as modified by MACRA and other Medicare legislation since 2010. Congressional and Administration responses to the highly significant Supreme Court’s “King v. Burwell” decision concerning the availability of federal subsidies in federal exchanges should clarify these partial versus total ACA repeal distinctions in the Congress.

**Perspectives on the Executive Branch and Reform Objectives.** The Department of Health and Human Services (DHHS), particularly in its Centers for Medicare and Medicaid Services (CMS), is proceeding rapidly to develop preliminary policies and actions to implement MACRA. As experienced government watchers know, new law is the tip of the iceberg. Congress sets a general legal framework, but the interpretation of the law and the development of policies to carry out the law is critical going forward. Early Administration policy approaches and execution on MACRA provisions is paramount, and should be the primary focus of physicians right now.

As implementation of MACRA shifts to the Executive Branch, complex factors come into play. These include regulators’ health system

and program reform objectives, experience gained from demonstrations, research findings, cost factors, administrative feasibility, intra- and inter-agency policy conflicts, and more. We can expect to see evidence of MACRA implementation details emerging quite soon, particularly in policies articulated through activities and releases of CMS (see Part II).

In previous reports on health reform (see [www.thephysiciansfoundation.org](http://www.thephysiciansfoundation.org)), the Physicians Foundation has examined the evolving health reform objectives and issues of the last several years. Our 2014 report on the Medicare program published the recently revamped CMS Mission Statement and Agency goals. The Mission Statement sets a broad template for CMS to employ all of the tools available to the Agency through its Medicare, Medicaid and other program authorities, in order to increase value in health care services through its (immense) purchasing and other powers. CMS’s stated objectives were nothing less than to achieve broad improvements in population health in the United States.

Finally, the most recent, revelatory documents concerning the breadth of the Agency’s reform objectives may be contained in their May 21, 2015 announcement of the establishment of the “Health Care Payment Learning and Action Network.” This was followed in short order by “Million Hearts:



Cardiovascular Disease Risk Reduction Model (May 28), the ACO Investment Model (June 2), and updates to the Learning and Action Network (June 10). On June 4, the Agency released its final rules for the Medicare Shared Savings Program, which appears in the June 9 Federal register. These and other materials are available at CMS's Medicare and Medicaid Innovation Center website ([innovation.cms.gov](http://innovation.cms.gov)).

Collectively, these documents suggest:

- an improved way of conducting business at CMS (more extensive outreach and greater experimentation),
- a strong focus on providers' accountability and contributions to systemic health care objectives, and
- a cross-sectional "policy incubation" approach that, in addition to medical and health system representatives and researchers, includes participation of major private payers and state officials.

Keeping these factors in mind, we turn now to Part II: The Physicians Foundation Medicare Watch List--Physician Payment Model Reforms: 2015 – 2025.

**The tools now required to succeed in medicine increasingly transcend the exceptional educational, financial and practice development costs individual physicians already incur to practice.**



## Part II ➤

# The Physicians Foundation Medicare Watch List Physician Payment Model Reforms: 2015 – 2025

**Overview.** Title I of MACRA provides a complex, multi-year series of changes to the payment models and related requirements under which physicians participate in the Medicare program. MACRA makes fundamental changes to the way Medicare payments to physicians shall be determined and updated, and to how they incentivize physicians. There are two major pathways: the Merit-Based Incentive Payment System (MIPS), and the Alternative Payment Model (APM) program.

It is important to note that MIPS modifies, but is still fundamentally based on, fee-for-service payment. Regarding APMs, CMS has been experimenting with accountable care organizations (ACOs) and other alternative payment models for several years or more. However, considerably more work must be done to further develop and “scale-up” such programs to the level and durability the law envisions in the future Medicare program.

MACRA provisions map-out the tools and mechanisms for the APM pathway that the Congress considers could eventually replace traditional fee-for-service based payment.

The law also requires research into and a Report to Congress on considerations for introducing APM concepts into the Medicare Advantage program. In the interim, the new law streamlines and tightens the fee-for-service model via the MIPS provisions. The government’s work on both paths will proceed simultaneously, meaning that physicians must address current changes that are the building blocks for the longer-term models.

**Medicare Watch List and Title I Highlights.** The Medicare Watch List provides an early action guide to help identify critical topics and multiple venues for action. In an appendix to this part, we also provide a summary of select payment model reform features of Title I, including areas of the law protected from judicial review. This is a companion piece to the Medicare Watch List and serves as a resource for those who find it helpful. It gives readers the flavor of the physician payment reform portion of the law, of how deeply arcane and prescriptive it is, and of how many key elements lie “within the discretion” of the Secretary of DHHS to interpret. Of course, readers who have already become well-acquainted with the new law may simply focus on the Medicare Watch List, as follows.

## The Physicians Foundation Medicare Watch List

### Physician Payment Model Reforms: 2015 – 2025

The Physicians Foundation Medicare Watch List (“Watch List”) is a *preliminary* identification of areas related to payment model reforms that, in our judgment, especially require the medical community’s vigilance and active participation. Our goal was to identify several important actionable topics and related venues for action, focusing on the first year to 18 months of MACRA implementation. We tackled this by dividing the Watch List into three sections, 1) Watch List Topics, 2) Regulatory Implementation Venues, and 3)



Special Other Intervention Points, appearing below in that order. Timing is discussed in each section, as needed. For general reference, regulatory timelines and key provisions of Title I can be found in the Appendices following the Watch List.

## Section I. Medicare Watch List Topics

➤ **FISCAL ACTIONS' IMPACT ON PHYSICIAN PAYMENT ADEQUACY.** A moment on the big picture. As we outline in Appendix II, MACRA creates a series of new legislated policies relating to episodic physician fee schedule freezes, updates, bonuses and budget neutrality calculations. Federal budget calculations drive legislative scoring, shape policy decisions in the Congress and the Administration, and can materially impact CMS physician payment calculations and the ultimate level of spending on physician services. The new law has materially different budgetary effects relative to the repealed sustainable growth rate (SGR) methodology. It is more stable due to updates being prescribed over the 10-year budget window, and despite the 2020-2025 conversion factor in the fee schedule being set at 0.0 percent. However, it is not clear how CMS will address the changes as they “crunch the numbers” and interpret altered budget neutrality provisions in the initial fee schedule calculations in the physician payment rule for 2016 (see section II below). Based on experience with past regulatory notices, this is a “high watch” item.

[Note: Over time, the general level of spending for physician services under Part B of Medicare is driven by the proportion of items and services paid for under the APM pathway vs. the MIPS pathway due to their relative, differential update and bonus opportunities. If a larger share of services is paid for under MIPS than was assumed in legislative scoring projections, effectively more money is being “drained” from aggregate levels of spending for physician services than Congress expects.]

**CMS ACTUARY'S VIEWS.** It is important to understand the levels and the major assumptions behind new baseline spending projections, not least because CMS's Chief Actuary recently expressed grave concerns about the ultimate adequacy of physician services funding levels

under the diverging MIPS and APM pathways, update schedules and bonus payment levels. On April 9, 2015, during H.R. 2's progress in Congress, the CMS Chief Actuary released a candid 9-page memorandum on the estimated financial effects of H.R. 2. He expressed grave concerns over the adequacy of Medicare payments to physicians in the out-years relative to increases in physicians' practice costs and other factors, and, in particular relative to the Medicare Economic Index (MEI). He also stated that “the implications of the long-range divergence of Medicare physician payment rates from the Medicare Economic Index are significant,” and “while H.R. 2 addresses the near-term concerns of the SGR system, the issues of inadequate physician payment rates are ultimately greater.”

**SCALING FACTORS IN PAYMENT ADJUSTMENTS.** In the longer-term, we flag that beginning in 2019 there are important ancillary adjustments in physician payment calculations known as “scaling factors” that will come into play. The law requires specified applications of scaling factors, which can be raised *or lowered*, in the calculation of certain MIPS performance payment adjustments for professionals. These scaling factors may not exceed certain levels (3.0) and interact with budget neutrality provisions with ultimate payment consequences for individual physicians that are unclear at this stage.

➤ **KEY BUILDING BLOCKS IN THE DEVELOPMENT OF THE MERIT-BASED INCENTIVES PAYMENT SYSTEM, OR MIPS.** The MIPS program will apply to payments for services and items furnished on or after January 1, 2019. Alternative Payment Models (APMs) are in development, but it is unclear over time what proportion of physicians will be participating in APMs and therefore not paid under MIPS rules. In the CMS Actuary's memorandum referenced earlier, it was assumed that 60-percent of Medicare spending on physician services in 2019 would be attributable to physicians practicing in APMs, due to the financial incentives, and that the percentage would increase thereafter. Even if this perhaps optimistic projection is realized, a sizable number of physicians could be paid under MIPS for indefinite periods. Also, many of the quality measure, resource use codes

Physicians must address current changes that are the building blocks for the longer-term models.

Despite APM development, many physicians could be paid under lower MIPS levels for a long time.

and other concepts inform regulatory policies under both models. Therefore, we recommend careful attention to the following:

- 1 ➤ Methodology for assessing the total performance of each MIPS professional (see Appendix for details on the four major performance categories, i.e. Quality, Resource Use, Clinical Practice Improvement Activities and Meaningful Use of Certified EHR Technology.
- 2 ➤ Procedures for calculating a composite performance score for each professional (Note that the Secretary has discretion in weighting performance categories, measures and activities.)
- 3 ➤ Use of the composite score in making incentive payments (Note that the Secretary establishes a performance threshold which can be, at the Secretary's discretion, the mean or median of the composite scores for all MIPS professionals; the choice can be changed every 3 years. See also first Watch List topic above raising flags about scaling factors and budget neutrality interactions with payment levels.)
- 4 ➤ Methods for providing confidential feedback to individual professionals on performance and payments.
- 5 ➤ Procedures and schedules for sunseting pre-MIPS incentive programs and impact on pre-MIPS payments, if any.
- 6 ➤ Rules process for Secretary of DHHS to update quality measures and other aspects of MIPS operations.
- 7 ➤ See #2 below regarding development of resource use codes under APM building blocks.

➤ **KEY BUILDING BLOCKS IN THE DEVELOPMENT OF ALTERNATIVE PAYMENT MODELS, OR APMS.** By November 1, 2016, the Secretary of DHHS is required to establish through rulemaking the criteria for physician-focused payment models, including models for specialist physicians. This requirement interacts with the work of the GAO-appointed committee known as the "Physician-Focused Payment Models Technical Advisory Committee" (see Section III for Committee details). Physicians will be financially incented under the law from 2019 on to participate in

APMs rather than MIPS. In addition, expanded demonstration authorities will allow for a broader array of APMs to be tested. (See Appendix II for more detail.) Key Watch items:

- 1 ➤ Follow the critical work of the Technical Advisory Committee and public notices and rulemaking. The APM pathway is less fleshed-out in the law and provides even greater areas of debate and uncertainty, but also perhaps, opportunity.
- 2 ➤ Resource use measures will be an important component in the future for both MIPS and APMs. The law requires the development of a) care episode and patient condition classification codes, b) patient relationship codes to set attribution to physicians or other practitioners, c) expanded claims for data collection purposes, and d) "groupier" methodologies in order to classify patients into similar care and condition groups. The latter must be published for comment not later than 180 days after enactment (most likely in the NPRM for the annual physician fee schedule rule for 2016).
- 3 ➤ Charge-based and related methodologies announced by CMS to assign resource use values (e.g. allowed Part A, Part B or even Part D charges, as appropriate.)

➤ **EXPANDING USES OF MEDICARE DATA BY QUALIFIED ENTITIES.** Beginning July 1, 2016 qualified entities can use Medicare claims data, combined with data from other sources, to evaluate the performances of suppliers and providers of services. Such data may be given or sold to authorized users for non-public use. A number of restrictions apply. We flag this simply to suggest review of any rules or further announcements on this law revision. Data is becoming extremely powerful, both in medicine and in private and public payer policies about what to pay for in health care services and how to pay for such services.

## Section II. Medicare Physician Payment Reform Regulatory Implementation Venues

**Introduction.** The Administration has numerous avenues through which to implement laws and develop supporting policies, while engaging



effectively with the general public and affected groups of individuals. Policy-making at DHHS, and more directly at the Centers for Medicare and Medicaid Services (CMS), is an enormous, multi-stakeholder process with numerous points of entry. The government's processes must follow the Administrative Procedures Act and other laws that regulate how government agencies and employees carry out their responsibilities, and how they interact with the public. From CMS's standpoint, at the apex is formal rulemaking, which when finalized, deepens and widens the body of administrative law implementing acts of the Congress. CMS also convenes advisory committees, workgroups and research panels; conducts town-hall meetings and field hearings; issues public Requests for Information (RFIs) and Medicare Advantage "Call Letters"; and, conveys public testimony to the Congress. CMS contracts with an array of private organizations, not just to aid in operational functions, but to carry out health services research related to programmatic responsibilities.

CMS has developed an increasingly robust website and list-serve system to convey information, or to invite participation and comments for research or policy development purposes. To an important extent, though, physicians and their representatives must proactively take steps to inform and avail themselves of these opportunities, including signing-up for major Medicare program notices, submitting written comments or requesting meetings. Where pertinent, we flag some of these specific opportunities throughout the Watch List.

#### **Near-Term Major Regulations Notices:**

➤ **CMS PROPOSED RULE ON CHANGES TO THE MEDICARE PHYSICIAN FEE SCHEDULE AND RELATED PART B CHANGES FOR 2016.** The single most comprehensive tool immediately available to the Administration to send "MACRA Messages" is the proposed and final rulemaking notice(s) published annually in the Federal Register by CMS to announce significant proposed, and final, changes to the Medicare physician payment system and related Part B changes. The physician payment system is based on calendar year changes—this fact and certain federal Administrative Procedure Act

requirements on regulatory comment period duration, and on deadlines for publication, suggest CMS will likely publish its first, major, post-MACRA materials in this notice in or around July 2015 for 2016 initial changes. Final rules are published not later than November 1.

These rules should be examined especially closely as they should provide an initial broad guide to CMS perspectives on MACRA requirements and to broader implementation plans. For instance, under Title I, with respect to MIPS, the Secretary must, through rulemaking, publish an annual final list of quality measures (not later than November 1) from which MIPS eligible professionals may choose those by which they would be evaluated for subsequent performance assessment purposes. CMS may use the existing physician payment and related Part B annual rules process as the vehicle to invite early comment on many of the payment model reform provisions.

➤ **CMS ANNOUNCEMENTS REGARDING THE MEDICARE SHARED SAVINGS PROGRAM.** CMS announced proposed rules to amend the MSSP program

**DHHS published a semi-annual regulatory agenda in late June. Key dates for certain Watch List topics and action venues appear in Appendix I.**





for accountable care organizations (ACOs) in December 2014 and the final rule, post-MACRA enactment, on June 4, 2015. CMS eased off of some of the more stringent risk-sharing ideas of the proposed rule in favor of more flexible final rules. However, although the progress of the ACO program is generally positive (despite some participant withdrawals), program issues and changes reveal the challenges the government faces in eliciting *voluntary* participation in such models.

It remains to be seen what combination of policies and financial incentives will induce the level of

voluntary physician participation sought under new APM provisions through 2025. We discuss CMS assumptions regarding physician participation levels in APMs in Section I under payment adequacy.

Physicians should continue to track the ACO program's key elements (risk-sharing formulas, risk adjustment methods, performance measures, participation rules, beneficiary assignment, etc.) as harbingers of the Agency's thinking (and challenges) on such issues as provisions unfold under the APM pathway of MACRA. These will also surface in notices and other sub-regulatory documents, supplementing regulations.

➤ **FINAL RULE(S) ON ELECTRONIC HEALTH RECORDS (EHRS) AND INCENTIVES.** In late March 2015, CMS and the Office of the National Coordinator for Information Technology (ONC) issued related, proposed rules governing health information technology (HIT). CMS's rule related to more advanced Stage 3 "meaningful use" and set a pathway to 2018 when all providers would report on the same definition, regardless of prior participation. ONC proposed a new 2015 electronic health record definition and a broader, more flexible certification program

to support its interoperability roadmap. A number of medical groups, including the American Medical Association (AMA) and the Medical Group Management Association (MGMA), are urging delay in finalizing these rules, particularly those at CMS, in part to allow time to digest MACRA-related provisions and implications.

➤ **MEDICARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT RULES FOR ACUTE CARE HOSPITALS, ET AL.** In Title I, the Secretary of DHHS, with regard to physician clinical performance categories (see Appendix), is encouraged to focus on outcome measures under the quality performance category. In addition, the Secretary is explicitly authorized to use measures derived from another payment system, including measures for *inpatient* hospitals. Use of hospital outpatient department measures is precluded, except for items and services furnished by emergency physicians, radiologists and anesthesiologists.

On April 30, 2015 CMS published a large notice of proposed rulemaking (NPRM) governing inpatient hospital prospective payment system rates, and proposed changes to quality measures, in quality reporting requirements, and in electronic health record incentive programs. In the 375-page NPRM (a Federal Register notice), CMS discussed its views and proposed changes to these and other matters that are conceptually similar to, and share broader objectives with, changes physicians are facing in their medical practices now and under MACRA. We suggest that physicians, or their representatives, examine the views of CMS, and positions taken, in the upcoming final rule in areas of interest shared by hospitals and physicians. Particular note should be taken of any MACRA-related statements of future policy directions of wider applicability.

➤ **2015 MEDICARE ANNUAL TRUSTEE'S REPORT.** The formally titled "2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds" is an important annual report examining the fiscal soundness of the Medicare program. Unlike the other items on this list, *the Trustee's Report is not an "actionable" item.*

However, its value goes beyond the important topic of Medicare’s fiscal soundness, due to the wealth of data and insights it provides about the impact of law, regulations and other changes to Medicare. The 2015 report is likely to contain important information about the estimated effects of the new MACRA provisions on spending for physician services over the next decade, and beyond, in Medicare. As noted in the “Fiscal Impact on Payment Adequacy” topic above, it is important to examine all the key decisions and sources of data that will have a bearing on the fiscal impact of regulations on adequacy of spending levels for physician services. Review of this report should be paired with review of budget neutrality and related payment level adjustments contained in preamble discussions in any physician fee schedule update or related regulations notices.

### ***Section III. Special Other Intervention Points Under Title I: Physician-Focused Advisory Committee and Organizations Preparing Early MACRA Reports to Congress***

Title I of MACRA provided for select advisory panels, and for Reports to Congress on issues of importance to physicians. The products of these efforts will shape the Administration’s and the Congress’s thinking about policy development and execution, and may lead to law changes. Development of the work-plans, including identification of data sources and other resources for such reports occur early, even for those produced under longer time-frames. We highlight these as additional opportunities to convey the concerns of and realities faced by practicing physicians.

➤ **PHYSICIAN-FOCUSED PAYMENT MODELS TECHNICAL ADVISORY COMMITTEE.** Not later than 180 days after enactment of MACRA, the Comptroller General of the General Accountability Office (GAO) is required to appoint 11 members to an ad-hoc committee to advise the Secretary of DHHS on the development and evaluation of alternative physician-focused payment models.

Payment models are to be assessed relative to criteria (yet) to be developed by the Secretary.

By November 1, 2016, the Secretary would establish through rulemaking the criteria for physician-focused payment models, including models for specialist physicians that could be used by the Committee for making comments and recommendations.

No more than 5 members are allowed to be providers or their representatives; federal employees *cannot* be Committee members. The Committee will be supported by the DHHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), and receive services from the CMS Office of the Actuary. Additional details are contained in the Appendix to Part II of this report, and in the following notice.

**Time-Sensitive Note:** This is a valuable Committee for ensuring direct input of physician perspectives into early formulation of APM approaches and standards at the highest levels of the Department of Health and Human Services. On June 8, **GAO released its announcement** titled “Notice on Letters of Nomination of Candidates” seeking applications for participation on this important Committee. For appointments to be made in October 2015, letters of nomination and resumes must be submitted by the **July 22, 2015 deadline**. Potential physician candidates should register their interest and qualifications rapidly with the Office of the Comptroller General as individuals, or work with professional organizations to support consensus candidates. The announcement appears in the June 9 Federal Register and can be accessed online as follows (<http://federalregister.gov/a/2015-13983>, and on [FDsys.gov](http://FDsys.gov).)

➤ **GAO REPORTS TO CONGRESS.** GAO is charged with a series of mandated reports to the Congress at multiple stages of development and evaluation of the MIPS program, including an early evaluation of the program after initial implementation. GAO exercises independent, “watch-dog” responsibilities over the actions and policies of federal agencies and reports directly to the Congress. It is important for physicians and their representatives to begin sharing the perspectives of practicing physicians early in GAO’s study formulation processes, even those with longer deadlines. To that end, we provide brief descriptions of the

The ‘Physician-Focused Payment Models Technical Advisory Committee’ ensures direct physician input in early stages of policy development.



Congressional oversight obligations imposed upon GAO by in Title I. The first two are nearer-term; the latter two have later deadlines.

- 1 ➤ **STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.** (Due 18 months after enactment.) GAO is charged with reporting on quality measures used in Parts A and B of Medicare, Medicaid, Medicare Advantage, and private payers. GAO is asked to especially focus on MIPS measures in the quality performance category, and to recommend ways to reduce the administrative burden of applying such measures. Physicians should be aware there is growing impetus for alignment across public and private health insurance programs of quality measures used in “paying for value” programs. This study is an early avenue for conveying concerns around measures, practice burdens, and private payer experiences.
- 2 ➤ **STUDY ON ROLE OF INDEPENDENT RISK MANAGERS.** (Due January 1, 2017.) GAO is charged with reporting on the role of independent risk managers and examining whether entities that pool financial risk for physician practices, such as independent risk managers, can play a role in supporting physician practices (particularly small physician practices), in assuming financial risk for the treatment of patients. The report would examine barriers that small physician practices currently face in assuming financial risk for treating patients, the types of risk management entities that could assist physician practices in participating in two-sided risk payment models, and how such entities could assist with risk management and with quality improvement activities. The report would also include an analysis of any existing legal barriers to such arrangements.
- 3 ➤ **STUDY TO EXAMINE RURAL AND HEALTH PROFESSIONAL SHORTAGE AREA ALTERNATIVE PAYMENT MODELS.** (Due not later than October 1, 2021.) This study will examine the transition of professionals in rural areas, health professional shortage areas,

or medically underserved areas to an alternative payment model. The report is to make recommendations for removing administrative barriers to practices to participate in such models, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas.

- 4 ➤ **EVALUATION OF THE MERIT-BASED INCENTIVE PAYMENTS SYSTEM FOR ELIGIBLE PROFESSIONALS.** (Due October 1, 2021.) This is to be an early, larger-scale evaluation of MIPS in order (1) to examine the distribution of the composite performance scores and MIPS adjustment factors and their patterns, including an analysis of the scores and factors across types of provider, practice size, geographic location, and patient mix, (2) to provide recommendations for improving the MIPS program, (3) to evaluate the impact of technical assistance funding on the ability of professionals to improve within the MIPS program or to transition successfully to an alternative payment model, with priority for evaluation given to practices located in rural areas, health professional shortage areas, and medically underserved areas, and (4) to provide recommendations for optimizing the use of such technical assistance funds.

**Note:** This could be a particularly important evaluation in the early stages of MIPS due to the fact that some of the enumerated factors in the study are system elements at the discretion of the Secretary and not subject to judicial review (see Appendix).

**CONCLUSION. MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC) REPORTS.** We close on a reminder that MedPAC has an ongoing role on behalf of the Congress in assessing the Medicare program in all its dimensions. MedPAC will be issuing general and specifically mandated reports touching on all the matters discussed above. Any serious, ongoing concerns or issues with CMS or DHHS policies in the areas above should be communicated to MedPAC officials on an ongoing basis.



# Appendix I: DHHS Regulatory Agenda (selective abstract)

This Agenda presents the rulemaking activities that the Department expects to undertake this year to advance this mission. The Agenda furthers several Departmental goals, including strengthening health care; advancing scientific knowledge and innovation; advancing the health, safety, and wellbeing of the American people; increasing efficiency, transparency, and accountability of HHS programs; and strengthening the nation’s health and human services infrastructure and workforce.

In the rules outlined for this Agenda, HHS continues its work to build a better, smarter, and stronger health care delivery system. Our aspiration is for patients to receive higher quality of care, for medical information to be easy to understand, and for health care dollars to be spent more wisely. We welcome the opportunity to build a more transparent health care delivery system and strengthen partnerships with patients, physicians, governments, and businesses. We continue our work by helping more people get and keep health insurance coverage and making health care more affordable for working families.

In addition, HHS strives to lead in the advancement of scientific knowledge and innovation to enable our nation’s scientists and researchers to continue making new and improved vaccines, cures, therapies, and rapid diagnostics. The accompanying regulations promote advancements in science, research, and innovation to attract the best experts to accelerate cures; reduce administrative burdens and duplication; and promote data sharing to protect the health of the American people.

HHS has an agency-wide effort to support the Agenda’s purpose of encouraging more effective public participation in the regulatory process and promote increase transparency to the public regarding our regulatory activity. For example, to encourage public participation, we regularly update our regulatory Web page (<http://www.HHS.gov/regulations>) which includes links to HHS rules currently open for public comment, and also provides a “regulations toolkit” with background information on regulations, the commenting process, how public comments influence the development of a rule, and how the public can provide effective comments. HHS also actively encourages meaningful public participation in its retrospective review of regulations, through a comment form on the HHS retrospective review Web page ([www.HHS.gov/RetropectiveReview](http://www.HHS.gov/RetropectiveReview)).

The rulemaking abstracts included in this paper issue of the Federal Register cover, as required by the Regulatory Flexibility Act of 1980, those prospective HHS rulemakings likely to have a significant economic impact on a substantial number of small entities. The Department’s complete Regulatory Agenda is accessible online at [www.RegInfo.gov](http://www.RegInfo.gov).

—C’Reda J. Weeden  
Executive Secretary to the Department

## 131. Electronic Health Record (EHR) Incentive Programs—Stage 3 (CMS-3310-F) (Section 610 Review)

*Legal Authority:* Pub. L. 111-5, title IV of Division B

*Abstract:* This final rule specifies the meaningful use criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to qualify for Medicare and/or Medicaid electronic health record (EHR) incentive payments and avoid downward payment adjustments under Medicare for Stage 3 of the EHR Incentive Programs. This rule also establishes an EHR reporting period for all providers under a calendar year timeline except for providers in the first year of the Medicaid EHR Incentive Program where states may continue to allow an introductory 90-day period; requires the electronic submission of clinical quality measures (CQMs); creates a single set of meaningful use requirements for Stage 3 which will be optional for providers in 2017 and applicable for all providers beginning in 2018; and ensure privacy and security requirements continue to protect patient health information (PHI).

### Timetable:

Action	Date	FR Cite
NPRM	03/30/15	80 FR 16732
NPRM Comment Period End	05/29/15	
Final Action	03/00/18	

*Regulatory Flexibility Analysis Required:* Yes.  
*Agency Contact:* Elizabeth S. Holland, Director, Division of HIT Initiatives, Department of Health and Human Services, Centers for Medicare & Medicaid



Services, Center for Clinical Standards and Quality,  
Mail Stop S2-26-17, 7500 Security Boulevard,  
Baltimore, MD 21244, Phone: 410 786-1309, Email:  
elizabeth.holland@cms.hhs.gov.

RIN: 0938-AS26

### **133. CY 2016 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1631-P)**

*Legal Authority:* Social Security Act, secs 1102, 1871, 1848

*Abstract:* This annual proposed rule would revise payment policies under the Medicare physician fee schedule, and make other policy changes to payment under Medicare Part B. These changes would apply to services furnished beginning January 1, 2016.

*Timetable:*

Action	Date	FR Cite
NPRM	06/00/15	

*Regulatory Flexibility Analysis Required:* Yes.

*Agency Contact:* John McInnes, Acting Director, Division of Practitioner Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicare, MS: C4-01-15, 7500 Security Boulevard, Baltimore, MD 21244, Phone: 410 786-0791, Email: john.mcinnis@cms.hhs.gov. Show citation box

RIN: 0938-AS40

### **134. Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2016 Rates (CMS-1632-F)**

*Legal Authority:* sec 1886(d) of the Social Security Act

*Abstract:* This annual final rule revises the Medicare hospital inpatient and long-term care hospital prospective payment systems for operating and capital-related costs. This rule implements changes arising from our continuing experience with these systems.

*Timetable:*

Action	Date	FR Cite
NPRM	04/30/15	80 FR 24323
NPRM Comment Period End	06/16/15	
Final Action	08/00/15	

*Regulatory Flexibility Analysis Required:* Yes.

*Agency Contact:* Donald Thompson, Deputy Director, Division of Acute Care, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicare, MS: C4-01-26, 7500 Security Boulevard, Baltimore, MD 21244, Phone: 410 786-6504, Email: donald.thompson@cms.hhs.gov. Show citation box

RIN: 0938-AS41

### **137. Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 Through 2017 (CMS-3311-F) (Section 610 Review)**

*Legal Authority:* 42 U.S.C. 1302 and 1395hh; Pub. L. 111-5

*Abstract:* This final rule changes the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program EHR reporting period in 2015 to a 90-day period aligned with the calendar year, and also aligns the reporting period in 2016 with the calendar year. In addition, this rule modifies the patient action measures in the Stage 2 objectives related to patient engagement. Finally, it streamlines the program by removing reporting requirements on measures which have become redundant, duplicative, or topped out through advancements in EHR function and provider performance for Stage 1 and Stage 2 of the Medicare and Medicaid EHR Incentive Programs.

*Timetable:*

Action	Date	FR Cite
NPRM	04/15/15	80 FR 20346
NPRM Comment Period End	06/15/15	
Final Action	04/00/18	

*Regulatory Flexibility Analysis Required:* Yes.

*Agency Contact:* Elizabeth S. Holland, Director, Division of HIT Initiatives, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality, Mail Stop S2-26-17, 7500 Security Boulevard, Baltimore, MD 21244, Phone: 410 786-1309, Email: elizabeth.holland@cms.hhs.gov.

*RIN:* 0938-AS58

**141. Medicare Shared Savings Program; Accountable Care Organizations (CMS-1461-F) (Section 610 Review)**

*Legal Authority:* Pub. L. 111-148, sec 3022

*Abstract:* This rule finalizes changes to the Medicare Shared Savings Program (Shared Savings Program), including provisions relating to the payment of Accountable Care Organizations (ACOs) participating in the Shared Savings Program. Under the Shared Savings Program, providers of services and suppliers that participate in an ACO continue to receive traditional Medicare fee for service (FFS) payments under Parts A and B and are eligible for additional payments from the ACO if they meet specified quality and savings requirements.

*Timetable:*

Action	Date	FR Cite
NPRM	12/08/14	79 FR 72760
NPRM Comment Period End	02/06/15	
Final Action	12/00/17	

*Regulatory Flexibility Analysis Required:* Yes.

*Agency Contact:* Terri Postma, Medical Officer, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Mail Stop C5-15-24, 7500 Security Boulevard, Baltimore, MD 21244 Phone: 410 786-4169, Email: terri.postma@cms.hhs.gov. Show citation box

*RIN:* 0938-AS06

# Appendix II: Title I Highlights of Physician Payment Model Reforms\*

Title I of MACRA is organized as follows:

## Title I—SGR Repeal and Medicare Provider Payment Modernization

- Sec. 101.** Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians' services
- Sec. 102.** Priorities and funding for measure development
- Sec. 103.** Encouraging care management for individuals with chronic care needs
- Sec. 104.** Empowering beneficiary choices through continued access to information on physicians' services
- Sec. 105.** Expanding availability of Medicare data
- Sec. 106.** Reducing administrative burden and other provisions

In brief, the payment model reform framework of Title I does the following:

- 1) Repeals the sustainable growth rate (SGR) methodology for determining updates to the MPFS, establishes specified annual fee updates in the short term, and puts in place a new method for determining updates afterwards.
- 2) Establishes a merit-based incentive payment system (MIPS) to consolidate and replace several existing incentive programs,
- 3) Incentivizes the development of, and participation in, alternative payment models (APMs), and
- 4) Makes other changes to Medicare physician payment statutes.

Before continuing, readers should keep in mind that the law precludes administrative or judicial review of the following:

- the methodology used to determine the amount of the MIPS adjustment factors, including for exceptional performance.
- the establishment of the performance standards and the performance period.
- the identification of performance category measures and activities and information made public or posted on the Physician Compare Internet website of the Centers for Medicare and Medicaid Services.

- the methodology developed and used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.
- the determination that an eligible professional is a qualifying APM participant and the determination that an entity is an eligible alternative payment entity.
- the determination of the amount of the 5% payment incentive for participation in APMs.

For the first few years after enactment, the law sets the annual Medicare Physician Fee Schedule (MPFS) payment updates. From January through June of 2015, the update is 0%; for the remainder of the year—July through December of 2015, the payments are increased by 0.5%. In each of the next four years, 2016 through 2019, the payment increase is set at 0.5% each year. For the following six years, from 2020 through 2025, the payment update would be 0.0%.

Beginning in 2026, there would be two update factors; one for items and services furnished by a participant in a new alternative payment model (APM, see below), and another for those who do not participate in an APM. The update factor for the APM participants would be 0.75% while those not participating in an APM would see an update factor of 0.25%.

### Initial Transition – Merit-Based Incentive Payment System.

The law creates a new incentive payment system while sun-setting several existing programs on the last day of 2018: (1) the meaningful use incentive program for certified electronic health record (EHR) technology, (2) the quality reporting incentive program currently called PQRI, and (3) the value-based payment modifier. The Secretary will establish a replacement program, the merit-based incentive payment system (MIPS) that would accomplish the following:

- develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards;
- using the methodology above, provide for a composite performance score for each professional for each performance period; and
- use the composite performance score of the MIPS eligible professional to make MIPS program incentive payments to the professional for the year.

**MIPS Effective Date.** The MIPS program applies to payments for items and services furnished on or after January 1, 2019.

**New Measures and Activities Related to Incentive Payments.** With the sun-setting of the incentive programs mentioned above, the *MIPS program would use a new set of measures and activities under four performance categories to determine whether an individual qualified for an incentive payment.* A composite performance score would be calculated for each MIPS eligible professional, which would be used to determine the incentive payment. The Secretary would use the following performance categories to determine the composite performance score.

- **Quality.** The final quality measures under current law for existing incentive payments for quality reporting and quality of care.
- **Resource use.** The measures of resource use established for the value-based modifier under current law and, to the extent feasible, accounting for the cost of Part D drugs.
- **Clinical practice improvement activities.** The clinical practice improvement activities would be specified by the Secretary and would include at least the following subcategories:
  - 1) **expanded practice access**, such as same day appointments for urgent needs and after-hours access to clinician advice;
  - 2) **population management**, such as monitoring health conditions of individuals to provide timely health care or participation in a qualified clinical data registry;
  - 3) **care coordination**, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth;
  - 4) **beneficiary engagement**, such as the establishment of care plans for individuals with complex care needs and beneficiary self-management assessment and training, and using shared decision-making mechanisms;
  - 5) **patient safety and practice assessment**, such as thorough use of clinical or surgical checklists and practice assessments related to maintaining certification; and
  - 6) **participation** in an alternative payment model.

**Special Circumstances Practices.** In establishing the clinical practice improvement activities, the Secretary would give consideration to the circumstances of small practices (15 or fewer professionals) and practices located in rural areas and in health professional shortage areas.

By November 1 of each year, the Secretary would establish and publish in the Federal Register an annual list of quality measures from which MIPS eligible professionals could choose, to serve as the basis for the MIPS payment adjustment. The list would be updated to remove measures that are no longer meaningful (e.g., when a measure is topped out) and to add new quality measures.

**MIPS Performance Standards.** The Secretary would establish MIPS performance standards and the performance period with respect to the measures and activities. The performance standards would take into account (i) historical performance standards, (ii) improvement, and (iii) the opportunity for continued improvement. The Secretary would establish a performance period for each year in which incentive payments would be determined, beginning with 2019; the performance period would begin and end prior to the beginning of the year in which the incentive payments would be paid.

**MIPS Composite “Performance” Score.** The Secretary would develop a methodology for assessing the total performance of each MIPS eligible professional according to the performance standards and the applicable measures and activities specified above and determine a composite assessment (“composite performance score”) for each such professional for each performance period. As incentive, the Secretary would treat those eligible professionals who fail to report on an applicable measure or activity that is required as achieving the lowest potential score applicable.

In weighting the performance categories to determine the composite performance score, 30% of the initial score would be based on performance on the quality measure; outcome measures would be encouraged, as feasible. The weight for the resource use category would also initially be 30%, while the clinical practice category would receive a weight of 15%. The meaningful use of certified EHR technology would receive 25% weight. These weights would change over time. For example, should the percentage of meaningful EHR users exceed 75%, the Secretary could reduce the weight for that category, but not below 15%, with the other weights increased appropriately.

The Secretary would be given flexibility in weighting performance categories, measures, and activities. The Secretary may assign different scoring weights (including a weight of 0) for:

- 1) each performance category based on the extent to which the category is applicable to the type of eligible professional involved, and
- 2) each measure and activity based on the extent to which the measure or activity is applicable to the type of eligible professional involved.

**MIPS Incentive Payment.** The Secretary would specify a MIPS program incentive payment adjustment factor for each MIPS eligible professional for a year, which would be determined by the composite performance score of the eligible professional for the year. The application of the adjustment factors would result in differential payments reflecting the professional's composite performance score relative to an established performance threshold.

Professionals with composite scores at the threshold would receive no adjustment; higher composite scores would receive higher adjustments and composite performance scores below the threshold would lead to a negative adjustment.

**MIPS Adjustment Factors.** The MIPS adjustment factor (positive or negative) would be 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and in subsequent years; each professional's MIPS adjustment factor would be between 0% and +/- (adjustment factor)%, reflecting his or her composite score between 0 and 100 on a sliding scale.

An **additional MIPS adjustment** could be earned for **exceptional performance**. For years 2019 through 2024, eligible professionals with a composite performance score at or above the additional performance threshold could receive an additional positive MIPS adjustment factor that would vary with the amount by which the score exceeds the threshold, to be specified by the Secretary.

The **performance threshold** would be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals; the Secretary could reassess the selection of the mean or the median every three years. The exceptional performance threshold would be determined in one of two ways: (1) the score equal to the 25th percentile of the range of possible composite scores higher than the performance threshold above, or (2) the score equal

to the 25th percentile of the actual composite scores for MIPS eligible professionals with scores at or higher than the performance threshold above.

**MIPS Initial Thresholds Transition.** For the first two years to which the MIPS applies, the Secretary would establish the two thresholds based on (i) information from a period prior to the performance period, (ii) data available with respect to performance on measures and activities that may be used in the four MIPS performance categories, and (iii) other factors the Secretary determines to be appropriate. Beginning with 2019, the payment received by a MIPS eligible professional would be the amount otherwise paid (under the MPFS) multiplied by the MIPS adjustment factor expressed as a percentage.

**Incentive Payment Limits.** The estimated aggregate increase in payments for additional MIPS adjustments for exceptional performance is to be \$500 million for each year from 2019 through 2024, subject to the restriction that the additional adjustment cannot exceed 10% for an eligible professional in a year. Thus, the aggregate increase in payments may be less than \$500 million if this restriction is applied. Each MIPS-eligible professional would be notified as to their MIPS adjustment factor (including the additional adjustment factor for exceptional performance) no later than December 2 (30 days prior to January 1) of the year before the adjustment factor would be applied. The MIPS adjustment factor(s) would apply only with respect to the year involved, and the Secretary would not take such adjustments into account in making payments to a MIPS eligible professional in a subsequent year.

**Physician Compare Website Posting.** The Secretary would make information regarding the performance of MIPS eligible professionals under the MIPS program available to the public, in an easily understandable format on CMS's Physician Compare Internet website. This information would include the composite score for each MIPS eligible professional and the performance of each MIPS eligible professional with respect to each performance category, and could include their performance on each measure or activity in the four performance categories. This information would indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.



**Physician Review Opportunity.** The Secretary would provide for an opportunity for an eligible professional to review, and submit corrections for, the individual's information to be made public prior to such information being made public. The Secretary would periodically post aggregate information on the MIPS program on the Physician Compare Internet website, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

**Technical Assistance to Select Practices.** To provide technical assistance to small practices and practices in health professional shortage areas, the Secretary would enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals with priority given to professionals located in rural areas, health professional shortage areas, or practices with low composite scores.

For purposes of implementing the technical assistance program, \$20 million from the Federal Supplementary Medical Insurance (SMI) Trust Fund would be made available to CMS for each of FY2016-FY2020. These amounts would be available until expended.

**Confidential Feedback on Performance.** In order to provide feedback to eligible professionals to improve performance, beginning July 1, 2017, the Secretary would make available timely (such as quarterly) confidential feedback to each MIPS eligible professional on the individual's performance with respect to the quality and resource use performance categories. Information on the clinical practice improvement activities and meaningful EHR use categories could also be provided. The Secretary could use one or more mechanisms to provide this feedback, including use of a web-based portal or other mechanisms determined appropriate by the Secretary.

**FOIA Disclosure Exemption.** The Secretary could use data from periods prior to the current performance period with respect to MIPS eligible professionals and could use rolling periods in order to make illustrative calculations about the performance of these professional. This feedback would be exempt from disclosure under the Freedom of Information Act (FOIA).

**Patient Services Provided by Other Professionals.** Beginning July 1, 2018, the Secretary would

make available to each MIPS eligible professional information about items and services furnished to the professional's patients by other suppliers and providers of services. This information would include the following: (1) the name of each provider furnishing items and services to such patients during the period, the types of items and services so furnished, and the dates these items and services were furnished, and (2) historical data, such as averages and other measures of the distribution if appropriate, of the total allowed charges as well as the components of the charges, as well as other figures as determined appropriate by the Secretary.

The Secretary would establish a process under which a MIPS eligible professional could seek an informal review of the calculation of the individual's MIPS program incentive payment. The results of such a review would not be taken into account for purposes of determining the MIPS adjustment factor and payments with respect to a year (other than with respect to the calculation of the eligible professional's MIPS program incentive payment for such year).

## **Pathway to Alternative Payment Models (APMs)**

**Parallel Track to APMs and Definitions.** On a parallel track to MIPS activities, the Secretary will develop alternative payment models. The term "**alternative payment model (APM)**" would be defined to mean any of the following:

- A model under the Center for Medicaid and Medicare Innovation (other than a health care innovation award);
- A Medicare shared savings program accountable care organization (ACO);
- A demonstration under Section 1866C of the Social Security Act;
- A demonstration required by federal law.

A key term is "**eligible alternative payment entity**" which means an entity that (i) participates in an APM that requires participants to use certified EHR technology and provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in the MIPS program established above, and (ii) bears financial risk for monetary losses under the APM that are in excess of a nominal amount, or is a medical home expanded under Section 1115(c) of the Social Security Act.



A “**qualifying APM participant**” is defined as:

- 1) For 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25% of payments for Medicare-covered professional services furnished by a professional during the most recent period for which data are available (which could be less than a year) were attributable to services furnished to Medicare beneficiaries through an entity eligible for participation in an eligible alternative payment model,
- 2) For 2021 and 2022, an eligible professional who meets either of the following criteria:
  - **Medicare payment threshold.** At least 50% of Medicare payments for covered professional services during the most recent period for which data are available were furnished to Medicare beneficiaries through an eligible APM; or
  - **Combination all-payer and Medicare payment threshold.** Satisfies conditions on (i) the amount of Medicare payments made under qualified APMs and (ii) payments made by other payers under arrangements in which quality measures, EHR technology, and other conditions apply.
  - **For 2023 and in subsequent years,** an eligible professional as described in (2) above, but meeting a criteria of 75% for the first threshold above and a similarly higher condition for the second.

A “**partial qualifying APM participant**” would be defined as an eligible professional who would fail to meet the appropriate revenue threshold to achieve a bonus payment under the qualified APM program but achieved a lower threshold. The Secretary would select one of the following low-volume threshold measurements to determine the above exclusion for the performance period:

- a minimum number of Medicare beneficiaries who are treated;
- a minimum number of items and services furnished, or;
- a minimum amount of allowed charges billed, all by the professional.

In each case, *the minimum number is determined by the Secretary.*

**Research Building Blocks for APMs and the Physician-Focused Payment Models Technical Advisory Committee.** To advise and evaluate the development of alternative payment models, the law establishes an ad

hoc committee to be known as the “Physician-Focused Payment Models Technical Advisory Committee” (“Committee”). The Committee shall provide comments and recommendations to the Secretary as to whether the alternative payment models meet the criteria (to be established by the Secretary) for assessing physician-focused payment models.

The Committee is to be composed of 11 members appointed by the Comptroller General, and include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee can be providers of services or suppliers, or their representatives. Federal employees are not be allowed to be members of the Committee. Members of the Committee will be required to publicly disclose financial and other potential conflicts of interest. The initial appointments, to be made no later than 180 days after enactment, will be staggered with three years being the length of a full term. Vacancies would be filled in the same manner as original appointments.

Committee members would serve without compensation (travel expenses would be allowed), and the Committee would meet as needed.

**DHHS-ASPE Committee Support Role.** The HHS Assistant Secretary for Planning and Evaluation will provide technical and operational support for the Committee, which could be by use of a contractor. The Office of the Actuary of the Centers for Medicare and Medicaid Services will provide actuarial assistance as needed. To establish and operate the Committee, the Secretary will transfer amounts as necessary from the SMI Trust Fund, not to exceed \$5 million for each fiscal year beginning in 2015.

**Deadline of November 2016 for Publication of Rule-Making Criteria for APMs.** The creation and recognition of alternative payment models under the Medicare program is to follow a process of submission, review, and evaluation. By November 1, 2016, the Secretary would establish through rulemaking the criteria for physician-focused payment models, including models for specialist physicians that could be used by the Committee for making comments and recommendations.

During the comment period for the proposed rule, MedPAC could submit comments to the Secretary on the proposed criteria. The Secretary could update the criteria through rulemaking. Individuals and stakeholder entities could also submit proposals to the Committee for physician-focused payment models that they believe meet the criteria.

The Committee would review models submitted on a periodic basis and provide comments and recommendations to the Secretary regarding whether the models meet the criteria. The Secretary would review the Committee's comments and recommendations and post a detailed response on the CMS website.

**APM Incentive Payments.** Eligible Medicare professionals would be incentivized to participate in Medicare APMs through higher payments. Beginning in 2019 and ending with 2024, eligible professionals in a qualifying APM providing covered services would receive payment for the services provided that year as well as an amount equal to 5% of the estimated aggregate payment amounts for covered professional services for the preceding year. The incentive payment would be made in a lump sum on an annual basis, as soon as practicable. *These incentive payments would not be taken into account for purposes of determining actual expenditures under an alternative payment model or for purposes of determining or rebasing any benchmarks used under the APM.*

**New Demonstration Authorities.** To encourage the development and testing of certain APMs, demonstration project authority regarding the testing of models (Section 1115A(b)(2) of the SSA) is amended to allow for models focusing:

- primarily on physicians' services, with particular focus on such services furnished by physicians who are not primary care practitioners,
- on practices of 15 or fewer professionals,
- on risk-based models for small physician practices that may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures, and
- primarily on Medicaid, working in conjunction with the Center for Medicaid and CHIP Services.

The demonstration authority is also modified to add "statewide payment models" in addition to "other public sector or private sector payers" as a factor for consideration.

**Other APM Studies, e.g. Medicare Advantage Integration and Application of Anti-Fraud Laws.** The provision would require additional studies regarding the development and testing of APMs. By July 1, 2016, the Secretary would submit to Congress a study examining

the feasibility of integrating APMs in the Medicare Advantage payment system; the study would include the feasibility of including a value-based modifier and whether such a modifier should be budget neutral.

**Fraud Laws.** No later than two years after enactment, the Secretary, in consultation with the HHS Inspector General (IG), would submit a study that would (1) examine the applicability of the federal fraud prevention laws to items and services furnished under the Medicare program for which payment is made under an APM; (2) identify aspects of APMs that are vulnerable to fraudulent activity; and (3) examine the implications of waivers to such laws granted in support of APMs, including under any potential expansion of APMs. The report would include recommendations for actions to be taken to reduce the vulnerability of such APMs to fraudulent activity and, as appropriate, recommendations of the IG for changes in federal fraud prevention laws to reduce such vulnerability.

**Infrastructure and Processes for Resource Use Measures Development.** To improve the measurement of resource use, and in order to involve physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement—including for purposes of the MIPS and the APMs as added by this provision, the bill would require the development of (1) care episode and patient condition groups and classification codes, patient relationship categories and codes to facilitate the attribution of patients and episodes to physicians or applicable practitioners, (3) expanded claims to gather more information for resource use measurement, and (4) a methodology for resource use analysis.

**New Classification Groups Required.** In order to classify similar patients into care episode groups and patient condition groups, the Secretary would be required to develop new classification codes. **No later than 180 days after enactment**, the Secretary would post a list of episode groups and related descriptive information as developed pursuant to the episode grouper (under current law). For 120 days after such posting, the Secretary would accept suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted as well as specific clinical criteria and patient characteristics in order to classify patients into (1) care episode groups and (2) patient condition groups.

**Codes and Expenditure Targets.** Taking into account this information, the Secretary would (a) establish

care episode groups and patient condition groups that account for a target of an estimated one-half of Part A and Part B expenditures (with the target increasing over time as appropriate), and (b) assign codes to the groups.

**Care Episode Groups.** In establishing the care episode groups, the Secretary would take into account the patient's clinical problems at the time items and services are furnished during an episode of care, such as the patient's clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished, and other factors as appropriate.

**Patient Condition Groups.** In establishing the patient condition groups, the Secretary would take into account the patient's clinical history at the time of the medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as three months), and other factors as appropriate such as eligibility for Medicare and Medicaid.

**Code Criteria and Characteristics—CMS Website Posting.** The Secretary would draft a list of the care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website **no later than 270 days after the end of the comment period.** For 120 days after posting the list, the Secretary would seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders including representatives of Medicare beneficiaries, regarding the care episode and patient condition groups and codes. The Secretary would use mechanisms in addition to notice and comment rulemaking that could include the use of open door forums, town hall meetings, or other appropriate mechanisms. No later than 270 days after the end of the comment period, the Secretary would post an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website.

**Annual Rulemaking re Codes and Groups.** The Secretary would revise the lists through rulemaking no later than November 1 of each year. The revisions could be based on experience, new information developed pursuant to the episode grouper, and input from the

physician specialty societies, applicable practitioner organizations, and other stakeholders.

**Attribution of patients and episodes to physicians or applicable practitioners.** To develop patient relationship categories and codes to facilitate the attribution of patients and episodes to physicians or applicable practitioners, the Secretary would develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time an item or service is furnished. These patient relationship categories would include different relationships of the physician or practitioner to the patient (and the codes could reflect combinations of such categories).

Finally, examples of such relationship categories might include a physician or practitioner who:

- considers himself or herself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
- considers himself or herself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
- furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
- furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
- furnishes items and services only as ordered by another physician or practitioner.

End of Summary

\*This summary is derived from two major sources. The first is an authoritative, *interim* summary prepared by the Congressional Research Service for the Congress during H.R. 2 deliberations (CRS. Report #R43962, March 26, 2015), and heavily redacted and reformatted for this Appendix. It was adjusted based on our review of the final law provisions as signed by the President (P.L. 114-10).

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