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ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

July 24, 2018

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "MACRA and MIPS: An Update on the Merit-Based Incentive Payment System"

On **Thursday, July 26, 2018 at 10:00 AM, in room 2123 of the Rayburn House Office Building**, the Subcommittee will hold a hearing titled "MACRA and MIPS: An Update on the Merit-Based Incentive Payment System."

I. THE SUSTAINABLE GROWTH RATE (SGR) AND THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

In March 2015, Congress passed H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) with overwhelming bipartisan support by a vote of 392-37. The Senate passed it shortly thereafter. On April 16, 2015, MACRA was signed into law.[1]

Congress' intention in passing MACRA was not only to repeal the flawed SGR formula, but also to realign payment incentives in Medicare to reward value over volume. MACRA offered two paths for physicians to make the shift away from a volume-based payment system to a value-based payment system that focuses increasingly on quality, value and accountability: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

II. THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS streamlines three prior quality performance incentive programs: the Physician Quality Reporting System (PQRS), Value-based Modifier (VBM), and Electronic Health Record

[1] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10.

(EHR) or Meaningful Use. MIPS also adjusts physician payments according to their performance under these measures. The three separate programs and their respective incentives and penalties sunset in 2016 and have been replaced by new MIPS categories: Quality, Improvement Activities, Promoting Interoperability (Meaningful Use), and Cost.[2] MIPS assesses the performance of eligible professionals in four categories, which are accorded different individual weightings. For 2019, the Centers for Medicare & Medicaid Services (CMS) proposes the following weightings: Quality (45 percent), Cost (15 percent), Improvement Activities (15 percent), and Promoting Interoperability (25 percent).[3]

Performance-based Medicare payment adjustments will begin in 2019. Adjustments (positive or negative) are capped at 4 percent in 2019 and will gradually increase to up to a 9 percent adjustment in 2022. Physicians at or above the performance threshold will be eligible for the upward adjustment, while individuals below the threshold will receive a negative adjustment. For 2019, CMS has set the performance threshold at 30 points, up from 15 points in 2018.[4]

MIPS offers additional positive adjustments for exceptional performance of up to ten percent and is capped at an aggregate of $500 million annually from 2019-2024. The bonuses given for exceptional performance are not required to be budget neutral and are derived from a separate designated fund.

A. MIPS Participation

Starting in 2017, healthcare providers could choose whether to participate in an APM or start participating in MIPS. Providers that significantly participate in an Advanced APM, defined as receiving at least 25 percent of Medicare payment or 20 percent of Medicare patients through an Advanced APM, are exempt from MIPS.[5]

Providers are also exempt from MIPS if they fall below the "low volume" threshold. For performance year 2017, CMS set the low volume threshold or exemption for those providers who see fewer than 100 Medicare Part B patients per year or have less than $30,000 in Part B

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[2] Centers for Medicare & Medicaid Services (CMS), *Quality Payment Program*: *MIPS Overview* (https://qpp.cms.gov/mips/overview).

[3] CMS, *Proposed Rule: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program* (https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions).

[4] CMS, *Proposed Rule for the Quality Payment Program Year 3* (www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf).

[5] CMS, *The Merit-based Incentive Program* (Nov. 29, 2016) (www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Merit-based-Incentive-Payment-System-MIPS-Overview-slides.pdf).

charges per year. For performance year 2018, CMS increased the low-volume threshold to $90,000 in Part B charges or fewer than 200 Medicare patients per year. [6] The impact of the increase was notable in that it removed a significant proportion of clinicians from the MIPS program.

For performance year 2019, CMS has proposed maintaining the low-volume threshold of $90,000 in covered charges, or fewer than 200 Medicare patients per year, and adding a third exemption route for clinicians providing less than 200 covered services. CMS also proposed allowing clinicians that meet the exemption criteria to opt into MIPS.[7]

B. Performance Categories and Scoring

The Quality category replaces the prior Physician Quality Reporting System (PQRS) and Quality Portion of the Value Modifier. Quality will be based upon six out of 300 available quality measures, which are chosen by the provider or group. The quality measures focus on evidence-based practices for various medical conditions. MIPS participants can earn bonus points by assessing additional quality or patient experience measures, which can add up to ten percent of the overall possible quality measure score. For the first performance year (based on reporting data from 2017), the Quality category accounts for 60 percent of the total MIPS Composite Performance Score. This percentage will gradually decrease to 30 percent in future years of the program.[8]

Clinical practice Improvement Activities (IA) is a new category in the MIPS program. It is comprised of activities within nine different areas that focus on: achieving health equity, integrating behavioral and mental health, beneficiary engagement, care coordination, emergency response and preparedness, expanded practice access, patient safety and practice assessment, population management, and participation in an APM. The IA category will account for 15 percent of the MIPS composite score.

The Promoting Interoperability program takes the place of the prior Medicare EHR Incentive Program also known as Meaningful Use. MIPS participants that do not have Certified EHR Technology (CEHRT) may apply for a Hardship Exception. MIPS participants are scored on objectives and measures such as e-Prescribing, health information exchange, provider to

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[6] CMS, *Final Rule: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year*, 42 CFR Part 414 (Nov. 2, 2017) (www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf).

[7] CMS, *Proposed Rule: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program* (https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf).

[8] CMS, *Quality Payment Program: Merit-based Incentive Payment System (MIPS), Scoring 101 Guide for the 2017 performance period* (www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/MIPS-Scoring-101-Guide.pdf).

patient exchange, and public health and clinical data exchange. For 2019, CMS has proposed adding two new interoperability measures to the e-Prescribing objective: query of prescription drug monitoring program and verification of an opioid treatment agreement.[9] The Promoting Interoperability category will be calculated as 25 percent of the MIPS composite score.[10]

Resource use or Cost Performance replaces the prior Value-Based Modifier category. For the first performance period, the cost performance category will not be calculated in the MIPS composite score and no additional data reporting is necessary. After 2017, the cost performance category will gradually increase to comprise 30 percent of the total MIPS performance score.

C. Recent Congressional Action

On February 9, 2018, as part of the bipartisan budget deal, Congress passed a set of amendments to ease the burden of the MIPS transition period. The additional flexibility granted to the agency will allow for a more gradual and incremental transition in MIPS performance scoring than what was originally established under MACRA.

Under MACRA, the Secretary is required to set the performance threshold for year three of the program (2019) at the mean or median of final scores for all MIPS-eligible clinicians. The amendments grant the Secretary additional flexibility in establishing the performance threshold for three additional years, to ensure a gradual transition to a performance threshold based on the mean or median of final scores in 2021.

The amendments also provide the Secretary with additional flexibility in the weighting of the Cost performance category. Instead of requiring this performance category to have a weight of 30 percent in performance year 2019, the weight is required to be not less than ten percent and not more than 30 percent for 2019, 2020, and 2021. For 2019, CMS has proposed setting the cost performance weighting at 15 percent.

III. ALTERNATIVE PAYMENT MODELS (APM)

MACRA provided another route to incentivize the movement away from volume-based payments by giving financial bonuses to providers who participate in Advanced Alternative Payment Models. An Alternative Payment Model (APM) is a payment approach that provides incentives for clinicians to provide high-quality, cost-effective care for a specific clinical condition, population, or episode of care. MACRA created Advanced APMs, which are alternative payment arrangements in which physicians accept some financial risk for the healthcare quality and cost outcomes of their patients (i.e. they are "on the hook" if actual expenditures exceed expected expenditures), in exchange for greater rewards.

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[9] CMS, *Proposed Rule: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program* (https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf).

[10] *Id.*

An Advanced APM must meet the following three criteria under MACRA: 1) require participants to use certified electronic health record technology; 2) provide payment for covered professional services based on quality measures comparable to those used in MIPS; and 3) require participating APM Entities to bear more than a "nominal" amount of financial risk for monetary losses. CMS has defined "nominal" risk to mean that at least eight percent of the average estimated total Medicare Part A and B expenditures for the Advanced APM entity is at risk, or 3 percent of expected expenditures for which an APM entity is responsible is at risk.[11]

Beginning in 2018, qualifying APM participants, who receive a significant portion of their Medicare revenue from APMs, will receive a five percent bonus annually through 2024. After this, qualifying APM providers are eligible for a 0.75 percent annual increase in their Medicare payments. Qualifying APM providers are not subject to MIPS. If a provider does not meet the APM "significant portion" threshold (initially 25 percent of Medicare revenue, or 20 percent of Medicare patients), he or she would remain in MIPS. Starting in 2021, the threshold may be reached by combining revenue from APM arrangements in Medicare and other payers.

IV. WITNESSES

Kurt Ransohoff, MD, FACP
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[11] CMS, *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models: Final Rule* (Nov. 4, 2016).