HHS | Hart Health Strategies Inc.

SGR Repeal and Medicare Provider Payment Modernization Act of 2015: Timeline of Implementation

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026+
Base Update	Jan–Jun: 0 July-Dec: 0.5	0.5%	0.5%	0.5%	0.5%	Base Conversion Factor Update of 0.0% each year						0.25%*
Electronic Health Record Incentive Program	EHR Incentives continue under current law				EHR Meaningful Use Incorporated into MIPS							
Physician Quality Reporting System	PQRS continues under current law				Quality reporting incorporated into MIPS							
Physician Value-Based Payment Modifier	VBM Continues under current law				Parts of VBM incorporated into MIPS							
"Merit Based" Incentive Payment System (MIPS), *****	N/A				(+/-) 4%	(+/-) 5%	(+/-) 7%	(+/-) 9%				
Alternative Payment Models	N/A				5% lump sum bonus on the previous year's covered professional services for "qualifying APM participants"****							0.75%

* In 2026 and subsequent years, the non-APM conversion factor will be set as "equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year."

** The Secretary has the authority to create additional MIPS bonuses for "exceptional performers."

*** "Partial Qualifying APM Participants" (as defined in the legislation) who report on applicable MIPS measures are considered to be a "MIPS eligible professional" in that year. The Secretary may also base the determination by using "counts of patients in lieu of using payments and using the same or similar percentage criteria . . .as the Secretary determines appropriate."

**** "APM Qualifying Participant": **2019-2020**: 25% of Medicare revenues furnished as part of an eligible APM; **2021-2022**: 50% of Medicare revenues furnished as part of an eligible APM; *or* professionals with at least 25% of Medicare revenues from services furnished as part of an eligible APM *AND* at 50% of all payer revenues (excluding VA and DOD) for services provided as part of an APM (provided that the professional is willing to provide data to CMS to be able to make that determination). **2023 and subsequent years**: 75% of Medicare revenues furnished as part of an eligible APM; *or* professionals with at least 25% of Medicare revenues from services furnished as part of an eligible APM *AND* at 75% of all payer revenues (excluding VA and DOD) for services provided as part of an APM (provided that the professional is willing to provide data to CMS to be able to make that determination). 2021 and subsequent years: The Secretary may also base the determination by using "counts of patients in lieu of using payments and using the same or similar percentage criteria . . .as the Secretary determines appropriate."

ADDITIONAL DATES & DEADLINES:

2015

January 1, 2015: The **Secretary** shall make payments "for **chronic care management services** furnished on or after January 1, 2015 . . ."

~ May 2015: Statutory change that automatically renews **Medicare opt-out** period for additional two year periods unless "not later than 30 days before the end of the previous 2-year period" provides notice to the Secretary. **(**Effective date "shall apply to affidavits entered into on or after the date that is 60 days after the date of enactment.")

~October 2015: The **Secretary** and **CMS** must make public a list of **episode groups** and related descriptive information ("not later than 180 days after the date of enactment"); the **Secretary** shall accept public input for 120 days after posting (eventually for **resource use analysis**).

~October 2015: Make appointments to the **Physician-Focused Payment Model Technical Advisory Committee,** which will provide recommendations on moving providers into alternative payment models ("180 days after date of enactment").

~October 2015: The **Secretary** and **HHS OIG** shall submit a report to Congress with legislative recommendations to amend fraud and abuse laws (e.g. Stark and Anti-Kickback Statute) in order to allow **gainsharing arrangements** that can improve care and reduce waste and inefficiency ("Not later than 6 months after the date of enactment.").

2016

January 1, 2016: The **Secretary** shall develop and post a **draft plan for development of quality measures** and accept comments through March 1, 2016. Secretary must post final plan for measure development no later than May 1, 2016.

February 1, 2016: The **Secretary** shall make publicly available the number and characteristics of **opt-out physicians and practitioners** and update annually.

~March 2016 The **Secretary** shall post a draft list of **patient relationship categories** and **codes** for **episode attribution methodology** purposes ("Not later than one year after the date of enactment . . ."); the **Secretary** shall seek comment for 120 days; not later than 240 days after comment period the **Secretary** shall post an operational list of **patient relationship categories** and **codes.**

~March 2016: The **Secretary** shall conduct a study and submit a report to Congress on the feasibility of mechanisms (e.g. a Website) that would allow users to **compare the interoperability of EHR products** ("not later than 1 year after the date of enactment").

July 1, 2016: **Secretary** must submit a report to Congress on the feasibility of including participation in **Alternative Payment Models into the Medicare Advantage** payment system; this should include feasibility of including a value-based modifier and whether such modifier should be budget neutral.

July 1, 2016: **Qualified Entities (QEs)** may use combined data to conduct additional non-public analyses for the purposes of assisting providers to develop and participate in quality and patient care improvement activities including developing new models of care.

July 1, 2016: **Qualified Clinical Data Registries (QCDRs)** may request **Medicare claims data** (and in certain circumstances Medicaid data) to link with clinical outcomes data and perform risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety. Costs of providing the data apply.

July 1, 2016: The **Secretary** shall establish metrics to determine whether the national objective of achieving widespread EHR interoperability is being met.

~September 2016: **GAO Report** on alignment of quality measures between public and private programs with recommendations on how to reduce **administrative burden of reporting** ("not later than 18 months after the date of enactment").

~October 2016: The **Secretary** shall post a draft list of **care episodes** and **patient condition codes** ("270 days after the end of the comment period"); The **Secretary** shall accept comments for 120 days; within 270 days the Secretary shall post an operational list of **care episode** and **patient condition codes** (and the criteria and characteristics assigned to such code).

November 1, 2016: The **Secretary**, through notice and comment, shall establish criteria for **physician-focused payment models** including for specialist physicians (that could also be used by the **Physician-Focused Payment Model Technical Advisory Committee** on which to make comments and recommendations).

2016: The **Secretary** shall post physician data ("similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released by the Secretary with respect to 2012") available on **Physician Compare** by 2016.

2017

January 1, 2017: **GAO Report** on whether **entities that pool financial risk** for physician practices (i.e. independent risk managers) can play a role in supporting physician practices.

~April 2017: The **Secretary** (in consultation with the **OIG**) shall conduct a study and send a report to Congress on **fraud and abuse laws and impact** on Alternative Payment Models ("not later than 2 years after enactment").

~April 2017: The **GAO** shall submit a report to Congress on studies on **telehealth and remote patient monitoring**, which shall include legislative and administrative recommendations ("not later than 24 months after the date of enactment").

May 1, 2017: The **Secretary** shall post a report on the **progress made in measure development** (to be conducted annually).

July 1, 2017: The **Secretary** shall make available timely ("such as quarterly") **performance feedback reports** for MIPS participants. The current Physician Feedback Reports requirements will end in 2017.

July 1, 2017: Initial **MedPAC Report** on total and rate of growth of physician and healthcare profession expenditures.

December 31, 2017: The **Secretary** shall submit a report to Congress on the use of chronic care management services by individuals living in rural areas and by racial and ethnic minority populations.

2018

July 1, 2018: The **Secretary** shall make available to MIPS participants data about items and services that are furnished to that MIPS' patients *by other providers and suppliers.*

December 31, 2018: **Congressional declaration** that it is a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide.

2019

July 1, 2019: **MedPAC Report** on spending on professional services from 2015-2019 and its impact on efficiency, economy, quality of care, access, and recommendations for future payment updates.

December 31, 2019: The **Secretary** shall submit a report to Congress in the event the Secretary makes a determination that we have not achieved national widespread EHR interoperability identifying the barriers to adoption and making recommendations that the Federal government can take to achieve adoption.

2021

July 1, 2021: Final **MedPAC Report** on total and rate of growth of physician and healthcare profession expenditures.

October 1, 2021: **GAO Report** on the MIPS program including the distribution of performance and performance scores of participants, recommendations for improvement, and the impact of technical assistance on the ability of professionals to transition to APMs (particularly for practices in HPSAs and MUAs).

October 1, 2021: **GAO Report** on transition of professionals in rural areas, HPSAs, and MUAs into APMs.

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