



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

\*\*\* "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."

\*\*\*\* "Qualifying APM Participant": **2019-2020**: 25% of Medicare payments furnished as part of an eligible APM; **2021-2022**: 50% of Medicare payments furnished as part of an eligible APM; **or** professionals with at least 25% of Medicare payments from services furnished as part of an eligible APM AND at least 50% of all payer payments (excluding VA, DOD, and in certain cases Medicaid) for services provided as part of an eligible 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 payments furnished as part of an eligible APM; **or** professionals with at least 25% of Medicare payments from services furnished as part of an eligible APM AND at least 75% of all payer payments (excluding VA, DOD, and in certain cases Medicaid) 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 . . .”
- STATUS:** Implemented. Via previous Physician Fee Schedule Final Rules, CMS has provided payment rules under the Chronic Care Management Codes. This will likely fulfill the subsequently enacted provision to pay for chronic care management services, although CMS reiterated its policies designed to pay for these services as part of the [CY 2016 Medicare Physician Fee Schedule final rule](#). CMS also added new chronic care management services under the CY 2017 Medicare Physician Schedule final rule, including chronic care management services for beneficiaries with behavioral health conditions.
- ~ 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.”)
- STATUS:** Implemented. CMS implemented this provision via a policy finalized in the [CY 2016 Medicare Physician Fee Schedule final rule](#).
- ~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**).
- STATUS:** Completed; ongoing work in progress. On October 16, 2015, CMS released a [request for comment related to episode group policies](#) (including comment on the two episode methodologies CMS currently utilizes as part of other programs). CMS also released a [supplemental episode group request for comment](#) in April 2016. CMS released a [draft list of episode groups and associated trigger codes](#) in December 2016, along with a document titled “[Episode Based Cost Measure Development for the Quality Payment Program](#)” for public comment. CMS has also posted more detailed information about their [design methodology and episode groups](#) on its website.

**~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”).

**STATUS:** Completed. On June 9, 2015, [the Federal Register published a GAO request for nominations to the PTAC](#). Nomination materials were due on July 22, 2015 for the October 2015 appointments. On October 9, 2015, the [GAO announced the PTAC committee appointments](#). The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) [posted the PTAC charter on its Website](#). The first meeting of the PTAC took place on [February 1, 2016](#), with following meetings generally taking place on a quarterly basis. The PTAC has also begun accepting proposals for physician-focused payment models for their review and consideration.

## **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.

**STATUS:** Completed. On May 2, 2016 posted the final [Quality Measure Development Plan](#). Per CMS, “updates to the Measure Development Plan will be published annually or otherwise as appropriate.”

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

**STATUS:** Incomplete.

**~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**.

**STATUS:** Completed; ongoing work in progress. In April 2016 CMS posted a [draft list](#) of patient relationship categories, with a public comment period that closed in August 2016. Based on preliminary responses, CMS released [modified proposals](#) for categories and codes in December 2016. Public comments were due in January 2017 and final categories and codes must be published by April 2017. Eligible clinicians will be required to report on these codes beginning January 1, 2018.

**~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”).

**STATUS:** Completed. The Office of the National Coordinator for Health Information Technology (ONC) released a [report](#) titled “Report on the Feasibility of Mechanisms to Assist Providers in Comparing and Selecting Certified EHR Technology Products” in April 2016 to meet the MACRA requirement.

**~April 2016:** 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 12 months after the date of enactment.”).

**STATUS:** Completed. CMS published an undated [report](#) titled “Report to Congress: Fraud and Abuse Laws Regarding Gainsharing or Similar Arrangements between Physicians and Hospitals As Required by Section 512(b) of the Medicare Access and CHIP Reauthorization Act of 2015.”

**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.

**STATUS:** Completed. CMS released this undated [report](#) titled “Report to Congress: Alternative Payment Models and Medicare Advantage.”

**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.

**STATUS:** Completed. CMS issued [final regulations](#) in the Federal Register on July 7, 2016 to expand how qualified entities may use and disclose data, as specified under Section 105 of MACRA.

**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.

**STATUS:** Completed. As specified in the [final regulation](#) issued in the Federal Register on July 7, 2016, CMS established a “Quasi-Qualified Entity” process for qualified clinical data registries to use to gain access to Medicare claims data. As such, CMS did not adopt any new policies or procedures in response to this MACRA requirement.

- July 1, 2016:** The **Secretary** shall establish metrics to determine whether the national objective of achieving widespread EHR interoperability is being met.
- STATUS:** Completed. The Office of the National Coordinator for Health Information Technology released its [metrics](#) in a document titled “Fulfilling Section 601(b)(1)(C) of the Medicare Access and CHIP Reauthorization Act of 2015”, after soliciting input via a [request for information](#) published in the Federal Register on April 8, 2016.
- ~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”).
- STATUS:** Complete. GAO submitted its [report to Congress](#) on October 13, 2016 titled “Health Care Quality: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures.”
- ~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).
- STATUS:** Incomplete. CMS released a [draft list of episode groups and associated trigger codes](#) in December 2016, along with a document titled “[Episode Based Cost Measure Development for the Quality Payment Program](#)” for public comment. CMS has also posted more detailed information about their [design methodology and episode groups](#) on its website. Eligible clinicians will be required to report on these codes beginning January 1, 2018.
- 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).
- STATUS:** Completed. CMS established criteria for physician-focused payment models in the [MACRA/Quality Payment Program Final Rule](#), which was released on October 14 and published in the Federal Register on November 4, 2016.

**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.

**STATUS:** Incomplete. While CMS has released [data through CY 2014](#) (released in May 2016), including via a searchable format, CMS has not integrated such data within Physician Compare.

## **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, particularly small practices, and barriers that small physician practices face in assuming financial risk.

**STATUS:** Completed. On December 9, 2016, GAO issued a [Report to Congress](#) titled “Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices” to meet this requirement.

**~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.

**STATUS:** Ongoing. In the [MACRA/Quality Payment Program Final Rule](#), which was released on October 14 and published in the Federal Register on November 4, 2016, CMS finalized that they will use the Quality and Resource Use Reports (QRUR) released on September 26, 2016 (reflecting performance in 2015 as assessed under the Value-Based Modifier program) as the first MIPS performance feedback provided under this requirement. CMS noted that they are using these existing reports, rather than devoting resources to creating duplicative reports, to meet the statutory deadline, but acknowledged that these reports will (1) not be available for clinicians without historical data and (2) only be available at the TIN level, so may not be helpful for individuals practicing as part of a TIN who want to be assessed at the individual level. CMS will release additional feedback via the 2017 QRURs (reflecting performance in 2016) in the fall of 2017 as a bridge until updated reporting for MIPS is provided.

**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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