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Passage of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): The "Doc Fix"

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The President has signed into law the bipartisan bill H.R. 2, the "Medicare Access and CHIP Reauthorization Act of 2015," which permanently repeals the flawed Sustained Growth Rate (SGR) formula and replaces it with a stable Medicare payment system that rewards physicians for providing high-quality, high-value healthcare.[1] Without this new law, physicians would have faced a 21.2 percent decrease in Medicare payment rates scheduled to take effect on April 1, 2015. The SGR formula was established under the Balanced Budget Act of 1997 (Public Law 105-33), and since 2001, the formula, if applied, would have resulted in reduced payment rates. Congress has overridden these reductions 17 times, but to date had failed to develop a permanent solution, much to the frustration of physicians participating in Medicare.

The new law replaces the SGR formula with positive rate increases for 4.5 years and implements a long-term Medicare value-based payment approach that harmonizes the features of the Physician Quality Reporting System (PQRS), Meaningful Use (MU), and the Value-Based Payment Modifier (VBM). It also incentivizes physicians to participate in Alternative Payment Models (APMs). Additionally, the law includes provisions to continue several other policies that, unless extended, would expire soon (often referred to as extenders).

The new law goes into effect immediately to address Medicare payment rates to physicians for services rendered April 1, 2015.

Key Provisions of the "Doc Fix"

The following describes the main provisions of the new law.

Permanent SGR repeal: The SGR formula is permanently repealed, averting the 21.2 percent cut scheduled to take effect April 1, 2015, and any future SGR adjustments.

Long-term schedule of updates: From January 2015 through June 2015, physicians will see a zero percent update. For the next 4.5 years, from July 2015 through 2019, physicians will be guaranteed a 0.5 percent update. From January 2020 through 2025, the law includes a zero percent update, i.e., the rates will remain at the 2019 level, but providers will be subject to adjustment through one of two mechanisms depending on whether the physician chooses to participate in an APM program or the Merit-based Incentive Payment System (MIPS). For 2026 and beyond, the update will be 0.75 percent for eligible APM participants (referred to as the qualifying APM conversion factor) and 0.25 percent for all others (referred to as the nonqualifying APM conversion factor).

The Merit-based Incentive Payment System (MIPS) quality program: The PQRS, MU, and VBM programs continue as currently designed from 2015 through 2018. Starting in 2019, the law sunsets these programs as individual programs and incorporates elements of them in the MIPS. MIPS-eligible professionals are evaluated using a composite score that results in positive or negative performance adjustments (budget neutral in aggregate). The composite score includes four factors (maximum weights for each factor provided in parentheses): quality (PQRS/30 percent), resource use (VBM/30 percent), meaningful use (MU/25 percent), and clinical practice

[1] https://www.congress.gov/114/bills/hr2/BILLS-114hr2rds.pdf.

improvement activities (15 percent). These percentages will be adjusted depending on whether they are applied to an individual physician or a group practice. When 75 percent or more of eligible professionals are meaningful users, the law allows for the weight of MU measures to be reduced, but not below 15 percent.

The Secretary of the Department of Health and Human Services (HHS) will establish an annual final list of quality measures from which MIPS-eligible professionals may choose for purposes of assessment. The Secretary will also establish performance standards that consider historical performance standards, improvement, and the opportunity for continued improvement.

Clinical improvement activities include topics such as expanded practice access (e.g., same-day appointments for urgent needs and after-hours access to clinician advice); population management (e.g., monitoring health conditions of individuals to provide timely healthcare interventions or participation in a qualified clinical data registry); care coordination (e.g., timely communication of test results, timely exchange of clinical information to patients and other providers, use of remote monitoring or telehealth); beneficiary engagement (e.g., establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms); patient safety and practice assessment (e.g., use of clinical or surgical checklists and practice assessments related to maintaining certification); and participation in APMs.

MIPS-eligible professionals include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups of such professionals. The MIPS includes both bonuses and penalties that are calculated using a sliding scale based on being above or below performance thresholds. The applicable percentage for either incentives or penalties is 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and onward. Additionally, the MACRA creates a fund for extra bonuses during the period 2019-2024 for physicians that demonstrate exceptional performance.

The Government Accountability Office (GAO) is to perform an evaluation of the MIPS program (not later than October 2021), examine alignment of quality measures used in public and private programs (not later than 18 months after enactment of the law), and conduct a study on whether entities that pool financial risk for physician entities can play a role in supporting physician practices that participate in two-sided risk payment models. The study is to examine all practices, but especially small physician practices, and must be conducted not later than January 1, 2017.

Incentives for physician participation in Alternative Payment Models: The law provides incentives for physicians to participate in ongoing and future new payment models such as accountable care organizations, patient-centered medical homes, and initiatives under Section 1115 waivers. Qualifying participants will receive annual bonuses of 5 percent for services in 2019-2024 and not be subject to MIPS requirements. Payment will be made in lump sum on an annual basis. To receive these bonuses, participants need to earn at least 25 percent of their Medicare revenue through an APM in 2019-2020, 50 percent in 2021-2022 and 75 percent in 2023 and onward either from Medicare or a combination from all payers. The provision also establishes a Technical Advisory Committee to review and recommend physician-developed APMs based on criteria developed through an open comment process. Not later than July 2016, the Secretary is to submit to Congress a study that examines the feasibility of integrating APMs in the Medicare Advantage payment system.

Establishment of "Physician-Focused Payment Model Technical Advisory Committee": The law establishes a committee that will consist of 11 members and will meet, as needed, to provide comments and recommendations to the Secretary, on physician-focused payment models.

Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, and following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the committee for making comments and recommendations.

Medicare Payment Advisory Commission (MedPAC) reports on utilization of and expenditures on physician services: MedPAC is to deliver several reports during the period 2017-2021, including one that examines the relationship between physician utilization and expenditures (including rates of increase) and utilization and expenditures in Parts A, B, and D (including rates of increase).

Development of care episode groups, patient condition groups, and classification code systems: To support both MIPS and APMs, the law calls for the development of healthcare episodes groups, patient condition groups and classification codes, all of which are to be developed using a public comment process. The classification system will be used for reporting by January 2018. These groups will include resources from Medicare Parts A and B, and possibly Part D (per Secretary's determination).

Funding for quality and resource use measure development, and technical assistance to small practices: The law appropriates $15 million per year, from 2015 to 2019, for quality measure development. If any measure is selected to be used to measure performance and is not endorsed by a consensus-based entity, the measure must have a focus that is evidence-based.

It also appropriates $20 million per year from 2016 through 2020 to assist practices of up to 15 professionals to participate in the MIPS or transition to new payment models.

Care management for patients with chronic care needs: The law establishes payment for chronic care management when performed by a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife. The payment can be made only to one provider for a particular patient. The law does not specify the unit of payment, but does state that an annual wellness visit or initial preventive examination does not need to be furnished as a condition for payment.

Interoperability of electronic health records by 2018 year end: The law sets a goal of interoperability of EHR systems by December 31, 2018. If this is not achieved, the Secretary has the option to adjust MU penalties and/or decertify EHRs.

Medical malpractice liability: Quality program standards of PQRS, MU and others cannot be used as a "standard of care" in medical liability actions.

Public information on physician services: Physician utilization and payment data, including data from Physician Compare, will be publicly released on an annual basis. Qualified entities will have broader authority to sell and provide nonpublic reports with explicit protections.

Reports on physician-hospital gainsharing and telemedicine: The law requires a report from HHS that will make recommendations to amend existing fraud and abuse laws, through exceptions, safe harbors, or other narrowly targeted provisions, to permit gainsharing or similar arrangements between physicians and hospitals. It also requires a report from the GAO on barriers to telemedicine and remote patient monitoring.

EHR interoperability: In the law, Congress declares that a national objective will be to achieve widespread exchange of health information by December 31, 2018. Widespread interoperability means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and healthcare providers on a nationwide basis.

Highlights of Medicare and Other Extenders

The law includes provisions to temporarily continue ten Medicare provider payment provisions that, unless extended, would expire soon (often referred to as Medicare extenders). For example, the law extends funding for the National Quality Forum to review, endorse and maintain quality and resource use measures through 2017. The law also extends the authority for Medicare Advantage plans for special needs individuals (MA-SNPs) through December 31, 2018.

Eleven other extenders are included as part of the law. Among these are two that will be permanently extended: (i) the Qualifying Individual Program, a program that assists Medicare beneficiaries with incomes between 120 percent and 135 percent of the federal poverty level in covering the cost of their Medicare Part B premiums, and (ii) the Transitional Medical Assistance (TMA) program, a program that allows low-income families to maintain their Medicaid coverage for up to one year as they transition from welfare to work.

Extension of the Children's Health Insurance Program (CHIP)

The law extends CHIP for two years, a program that covers more than 8 million children and pregnant women in families that earn income above the Medicaid eligibility levels. While CHIP is authorized through 2019, no new funding is available after FY 2015. This provision preserves and extends CHIP funding through FY 2017. It also extends related services such as Express Lane Eligibility and the outreach and enrollment program for the CHIP program for two years.

Key Provisions of Offsets

Although the law affects direct spending and revenues, it waives pay-as-you-go procedures that would otherwise apply. The law includes the following offsets, which address some, but not all, of the estimated outlays.

Eliminates Medigap first-dollar coverage: Beginning in 2020, new Medigap plans sold will limit coverage to costs above the amount of the Part B deductible (currently $147 per year).

Adds income-related premium adjustment for Parts B and D: Beginning in 2018, this policy will increase the percentage that Medicare beneficiaries with modified adjusted gross income between $133,501 and $160,000 ($267,001-$320,000 for a couple) will pay from 50 percent to 65 percent. Beneficiaries that earn $160,001 and above ($320,001 and above for a couple) will pay 80 percent. Starting in 2020, this policy will update the threshold for inflation based on where beneficiaries were in 2019.

Post-acute provider market basket updates: Medicare payments to skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospices, and long-term care hospitals will be limited to increases of no more than 1.0 percent in FY 2018.

Medicaid Disproportionate Share (DSH) cuts: Under current law, state allotments for Medicaid DSH payments are increased each year by the percent change in the Consumer Price Index and then adjusted by scheduled reductions. The new law will increase net allotments in 2017 through 2020 and decrease net allotments in 2021 through 2025.

Phased adjustment to inpatient hospital payment rates: Instead of receiving a single-year 3.2-percentage-point increase in FY 2018, inpatient hospitals paid under Medicare's Inpatient Prospective Payment System will see the increase phased in over six years (0.5 percent per year) beginning in FY 2018 through FY 2023.

Levy on Medicare providers for nonpayment of taxes: This provision increases the levy from 30 percent to 100 percent against Medicare service providers with tax delinquencies.

Conclusion

This bipartisan agreement ends the cycle of annual short-term fixes, which have occurred 17 times since 2001. The law fully repeals the SGR formula and replaces it with a gradual evolution to a new value-based physician payment system. Initially, physicians will see modest annual updates to the existing fee-for-service system coupled with increasing opportunity to earn pay-for-performance bonuses and to participate in APMs involving performance goals and shared risk. The law supports this transition with various studies, evaluations and system requirements to guide the development of the new value-based payment approach.

The law also extends several Medicare and other policies that would have expired without congressional intervention, including preserving and extending CHIP funding through FY 2017.

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