Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. Law 114-10

AMA section-by-section summary

H.R. 2, the "Medicare Access and CHIP Reauthorization Act of 2015" or "MACRA," was passed by the U.S. House of Representatives on March 26 (by a vote of 392 to 37) and the Senate on April 14 (by a vote of 92 to 8), and signed into law on April 16, 2015. This bipartisan legislation permanently repeals the sustainable growth rate (SGR) formula and stabilizes Medicare payments for physician services with positive updates from July 1, 2015, through the end of 2019, and again in 2026 and beyond. It replaces Medicare's multiple quality reporting programs with a new single "MIPS" program that makes it easier for physicians to earn rewards for providing high-quality, high-value health care, and it supports and rewards physicians for participating in new payment and delivery models to improve the efficiency of care while preserving fee-for-service as an option. In addition, it preserves the current 10-day and 90-day global periods for over 4,000 surgical service codes that Medicare had planned to unbundle. Here is a detailed section-by-section summary of MACRA.

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

Sec. 101. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians' services.

Permanent SGR repeal. The SGR formula is permanently repealed, avoiding the 21.2 percent Medicare physician payment cut scheduled to take effect on April 1, 2015, and preventing SGR cuts in future years.

Positive updates for 4 1/2 years. The law includes annual updates (for Medicare Physician Fee Schedule services) of: 0 percent for January 2015 through June 2015; 0.5 percent for July 2015 through 2019; and 0 percent for 2020 through 2025. For 2026 and beyond, the update will be 0.75 percent for eligible alternative payment model (APM) participants and 0.25 percent for all others. The Medicare Payment Advisory Commission (MedPAC) must report to Congress by July 1, 2019, with "recommendations for any future payment updates for professional services under such program to ensure adequate access to care is maintained by Medicare beneficiaries."

The "Merit-based Incentive Payment System" (MIPS) quality program. Beginning in 2019, MACRA provides bonuses for physicians who score well in the MIPS, a new pay-for-performance program under the current Medicare fee-for-service payment system. Current penalties under the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM) will end at the close of 2018. In 2019, the MIPS program will become the only Medicare quality reporting program. Performance and "composite scores" under the MIPS will be based upon four categories: quality (PQRS/30 percent); resource use (VBM/30 percent); MU (25 percent); and clinical practice improvement activities (15 percent). These will build and improve upon the current quality measures and concepts in PQRS, MU, and VBM. Physicians are specifically encouraged to report quality measures through certified EHR technology or qualified clinical data registries. Participation in a qualified clinical data registry will also qualify as a clinical practice improvement activity.

In many respects, the MIPS program should be more attainable for physicians than current quality programs. The MIPS program presents the first real opportunity for high-performing physicians to earn substantial bonuses, and for all physicians to avoid penalties if they meet prospectively-established quality thresholds. Several new aspects of the MIPS program support physicians scoring better, and receiving more credit for their efforts, than under current programs. Performance scoring under the MIPS program has several advantages over current quality programs:

o **Sliding scale assessment.** Performance assessment under the MIPS program will be according to a "sliding scale"—versus the current "all or nothing" approaches used in PQRS and MU. Credit will be provided to those who partially meet the performance metrics.

o **Flexible weighting.** The law has guidelines for the weighting of the four performance categories, yet specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.

o **Credit for CPI and improvement.** Physicians can receive substantial credit for clinical practice improvement (CPI) activities and for improving (and achieving) quality of care.

o **Risk adjustment.** The MIPS will require risk adjustment for patients' "health status and other risk factors," including socio-economic factors.

o **Exemptions for APM participation and few Medicare patients.** Physicians with a low level of Medicare claims, and those who are in qualifying APMs, will be exempt from the MIPS requirements and payment adjustments (discussed below).

o **Timely feedback and solid performance targets.** At the start of each performance period, physicians will know the threshold score for successful performance. The Secretary of the Department of Health and Human Services must issue timely (such as quarterly) confidential feedback on physicians' performance on quality and resource use, and may include CPI and MU. Annual performance targets are based on the mean/median composite score of all MIPS eligible professionals for a prior period. Exceptional performance is set at the 25th percentile of the highest possible MIPS composite score, or of actual scores above the regular target.

o **Quality measures build upon existing measures, with some new flexibility.** The MIPS adopts existing PQRS, QCDR (Qualified Clinical Data Registry), and VBM measures. For quality and resource use, the Secretary may use measures for a payment system other than for physicians, such as those for inpatient hospitals. Measures for hospital outpatient departments can only be used for items and services furnished by emergency physicians, radiologists, and anesthesiologists. Evidence-based quality measures can be adopted without endorsement by the National Quality Forum. A report will address aligning public and private measures and reducing administrative burden.

o **Telehealth and remote patient monitoring** are expressly recognized as examples of "Clinical Practice Improvement Activities," along with care coordination, population health management, and monitoring of health conditions.

o **Group practices can report via Qualified Clinical Data Registries (QCDRs).** MACRA allows group practices to report via QCDRs, starting in 2016, and encourages eligible professionals to use these registries for MIPS reporting. QCDRs will also have access to Medicare claims data to inform and assist their activities.

The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing high quality of care. Physicians with composite scores below the performance threshold will incur MIPS penalties, on a sliding scale, with maximum penalties of up to: 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and beyond. For exceeding the performance threshold, physicians will be able to earn substantial MIPS bonuses, also on a sliding scale, with the highest bonus at least as high as the highest penalty for that year (e.g., 4 percent in 2019). (Some bonuses could go even higher, up to three times the maximum penalty levels, but the total of these bonuses and penalties must essentially balance one another.) Additional funding is provided for separate bonuses of up to 10 percent for exceptional performance, up to $500 million per year, from 2019 through 2024. So even if all physicians score above the threshold, some will still receive incentive payments. Unlike the current programs, the MIPS penalties provide greater certainty and have a maximum range in future years.

$100 Million for technical assistance to small practices. $20 million per year, from fiscal years 2016 through 2020, will assist practices of up to 15 professionals to participate in the MIPS program or transition to new payment models. Small practices (up to 10 MIPS-eligible professionals) can also elect to report together as "virtual groups" and receive a MIPS composite score for their combined performance.

Alternative payment models (APMs). The law provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Qualified patient-centered medical homes, widely recognized to lower costs of care, would not be required to assume downside financial risk. Other eligible APMs will be required to involve "more than nominal" financial risk. To encourage physicians to participate in APMs and to help offset investments or other costs they may incur, the legislation provides 5 percent bonus payments from 2019 to 2024 for those who join new models, in addition to the opportunities for increased revenues that many APMs provide if the physician practice generates savings. This provides a transition period to support successful implementation of new models. Another advantage is that physicians would only be subject to the quality reporting requirements for their APM; they would be exempt from the MIPS program. MACRA creates an advisory panel to consider physicians' proposals for new models and authorizes coverage for telehealth services in APMs, even if the service is not otherwise covered by the traditional Medicare program. By November 1, 2016, the Secretary must establish criteria for the advisory panel to use in making recommendations on APMs. The Secretary must first issue a request for information and then a proposed rule before establishing the criteria. By July 1, 2016, the Secretary must submit a study to Congress on the feasibility of integrating APMs into Medicare Advantage.

By July 1, 2017, MedPAC must submit a report to Congress on how physician spending and ordering patterns relate to spending under Parts A, B, and D. A final report is due by July 1, 2021.

Sec. 102. Priorities and funding for measure development.

$15 million per year, from fiscal years 2015 to 2019 (totaling $75 million), could go to physicians, physician groups, and the Physician Consortium for Performance Improvement® (PCPI®). New evidence-based measures can be adopted without endorsement by the National Quality Forum, and measures must be developed in close collaboration with physicians and other stakeholders. By January 1, 2016, the Secretary must develop (and post on the CMS website) a draft plan for the development of new quality measures, and accept public/stakeholder comments on the draft plan through March 1, 2016. The operational plan must be finalized and posted on the CMS website by May 1, 2016. The final list of MIPS measures will be issued by November 1, 2016, and will be updated annually.

Sec. 103. Encouraging care management for individuals with chronic care needs.

Beginning January 1, 2015, Medicare is required to reimburse, under at least one payment code, monthly care management services for individuals with chronic care needs. Payment will go to one professional practicing in a patient-centered medical home or comparable specialty practice certified by a recognized organization. No linkage is required to an annual wellness visit or initial preventive physician examination.

Sec. 104. Empowering beneficiary choices through continued access to information on physicians' services.

Physician Medicare claims data will be released annually, beginning in 2015. Beginning in 2016, the Secretary will integrate this information on Physician Compare.

Sec. 105. Expanding availability of Medicare data.

Beginning July 1, 2016, Qualified Entities (QEs) will have broader authority to sell and provide non-public reports with explicit protections.

Sec. 106. Reducing administrative burden and other provisions.

Beginning on June 15, 2015, physicians who choose to opt out of Medicare to engage in private contracting can elect to automatically renew their status (i.e., they will no longer be required to renew their opt-out status every two years). No later than February 1, 2016, regular reporting is required on the number of physicians who choose to opt out of Medicare.

By October 16, 2015, the Secretary must report to Congress with recommendations for safe harbors from fraud and abuse laws to permit gainsharing or similar arrangements between physicians and hospitals to improve care and efficiency while reducing waste.

Electronic health records (EHRs)—MACRA sets a goal of achieving "widespread interoperability" nationwide of EHR systems (across certified EHR systems employed by meaningful users, clinicians, and other health care providers) by December 31, 2018. If the goal is not achieved by that date, the Secretary can seek to adjust MU penalties and/or decertify EHRs. By July 1, 2016, the Secretary must establish, in consultation with stakeholders, the metrics to determine if this goal has been achieved. The Secretary must submit a report to Congress by April 16, 2016, on mechanisms that would assist physicians in comparing and selecting among certified EHR products. Information blocking by MU professionals and hospitals is prohibited, effective April 16, 2016.

The Government Accountability Office must conduct studies and report back to Congress, by April 16, 2017, on the use of telehealth under federal programs and remote patient monitoring technology and services.

The law incorporates the Standard of Care Protection Act, which prohibits quality program standards (of PQRS, MU, MIPS, etc.) from being used as a "standard of care" in medical liability actions.

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A—Medicare Extenders

Sec. 201. Extension of work GPCI floor.

Extends the existing 1.0 Geographic Practice Cost Index (GPCI) floor on the physician work cost index until January 1, 2018.

Sec. 202. Extension of therapy cap exceptions process.

Allows patients to exceed the caps on physical therapy, occupational therapy, and speech-language therapy through December 2017, and reforms the medical manual review process.

Sec. 203. Extension of ambulance add-ons.

Extends these add-ons until January 1, 2018.

Sec. 204. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.

Extends special add-on payments until October 1, 2017.

Sec. 205. Extension of the Medicare-dependent hospital (MDH) program.

Special payments to rural hospitals (up to 100 beds) serving a high percentage of Medicare patients will continue until October 1, 2017.

Sec. 206. Extension for specialized Medicare Advantage plans for special needs individuals.

Extends authority for MA special needs plans (SNPs) that can serve certain populations, such as dual-eligibles or those with certain chronic conditions, through December 31, 2018.

Sec. 207. Extension of funding for quality measure endorsement, input, and selection.

Funds the National Quality Forum at $30 million for each fiscal year from 2015 through 2017.

Sec. 208. Extension of funding outreach and assistance for low-income programs.

Provides funding through September 30, 2017, for Medicare education through State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Centers, the National Center for Benefits Outreach and Enrollment, and other programs.

Sec. 209. Extension and transition of reasonable cost reimbursement contracts.

Allows cost plans no longer meeting requirements to operate under Medicare in their area, and sets rules and beneficiary protections for cost plans transitioning to Medicare Advantage plans.

Sec. 210. Extension of home health rural add-on.

Extends three percent add-on for home health services in rural areas until January 1, 2018.

Subtitle B—Other Health Extenders

Sec. 211. Permanent extension of the qualifying individual (QI) program.

Makes permanent the "qualifying individual" program that subsidizes Medicare Part B premiums for beneficiaries earning 120-135 percent of federal poverty levels.

Sec. 212. Permanent extension of transitional medical assistance (TMA).

Makes permanent "transitional medical assistance," which provides Medicaid coverage as low-income families transition from unemployment to working.

Sec. 213. Extension of special diabetes program for type I diabetes and for Indians.

Extends funding through fiscal year 2017 for the Type I Diabetes and Type II Indian Health Service programs.

Sec. 214. Extension of abstinence education.

Extends funding for abstinence-only education through fiscal year 2017.

Sec. 215. Extension of personal responsibility education program (PREP).

Extends funding for prevention of teen pregnancy, HIV, and other STDs through fiscal year 2017.

Sec. 216. Extension of funding for family-to-family health information centers.

Extends funding through fiscal year 2017 for family-led organizations to serve other families of children with disabilities and other special health care needs.

Sec. 217. Extension of health workforce demonstration project for low-income individuals.

Extends funding through fiscal year 2017 for the healthcare workforce demonstration project that educates and trains low-income individuals in health care jobs.

Sec. 218. Extension of maternal, infant, and early childhood home visiting programs.

Extends funding through fiscal year 2017 for the Maternal, Infant and Early Childhood Home Visiting Program that gives grants to states, territories, and tribes for in-home visits for at-risk families.

Sec. 219. Tennessee DSH allotment for fiscal years 2015 through 2025.

Provides Tennessee with a disproportionate share hospital (DSH) allotment that gives it parity with other states.

Sec. 220. Delay in effective date for Medicaid amendments relating to beneficiary liability settlements.

Delays until October 1, 2017, a provision of the Bipartisan Budget Act of 2013 that would allow a state to recover third-party liability settlements and judgments received by Medicaid beneficiaries.

Sec. 221. Extension of funding for community health centers, the National Health Service Corps, and teaching health centers.

Extends funding through fiscal year 2017 for community health centers, the National Health Service Corps, and the Teaching Health Center Graduate Medical Education Payment Program, which provides residency training in community-based settings for family and internal medicine, pediatrics, ob-gyn, and psychiatry (as well as dentistry).

TITLE III—The Children's Health Insurance Program (CHIP)

Sec. 301. Two-year extension of the Children's Health Insurance Program.

Funding is extended through fiscal year 2017 for CHIP, currently serving over 8 million children and low-income pregnant women; the Child Enrollment Contingency Fund, for states facing a shortfall that meet an average enrollment target; and the qualifying states option that lets states use CHIP funds to expand Medicaid for children rather than setting up a separate program.

Sec. 302. Extension of express lane eligibility.

Funding is extended through fiscal year 2017.

Sec. 303. Extension of outreach and enrollment program.

Funding for this program, which provides grants to support enhanced outreach and enrollment campaigns, is extended through fiscal year 2017.

Sec. 304. Extension of certain programs and demonstration projects.

Extends funding through fiscal year 2017 for the childhood obesity demonstration project and the pediatric quality measures program.

Sec. 305. Report of Inspector General of HHS on use of express lane option under Medicaid and CHIP.

Calls for an HHS Office of Inspector General report, by October 16, 2016, on the use of the express lane option under Medicaid and CHIP and the extent to which individuals enrolled through this option actually meet Medicaid or CHIP eligibility requirements.

TITLE IV—OFFSETS

Subtitle A—Medicare Beneficiary Reforms

Sec. 401. Limitation on certain Medigap policies for newly eligible Medicare beneficiaries.

Prevents Medigap plans from offering "first-dollar coverage," which covers 100 percent of out-of-pocket costs (deductibles and co-payments). Starting in 2020, Medigap plans for new enrollees will be limited to covering costs above the Part B deductible, currently $147 per month.

Sec. 402. Income-related premium adjustment for parts B and D.

Medicare beneficiaries with higher incomes will start paying more premium costs (under Medicare Parts B and D) starting in 2018. These will be subject to inflation adjustments beginning in 2020. The current premium contributions will remain in effect (and subject to inflation adjustments) through 2017.

Subtitle B—Other Offsets

Sec. 411. Medicare payment updates for post-acute providers.

Limits increase to no more than 1.0 percent in fiscal year 2018.

Sec. 412. Delay of reduction to Medicaid DSH allotments.

Delays cuts in disproportionate share hospital payments until fiscal year 2018, and adds another year of cuts in 2025.

Sec. 413. Levy on delinquent providers.

The Federal Payment Levy Program (FPLP) allows the government to collect overdue taxes through a levy on certain federal payments, including Medicare provider and supplier payments. H.R. 2 increases the existing levy rate from 30 percent to 100 percent.

Sec. 414. Adjustments to inpatient hospital payment rates.

A 3.2 percent increase in the base rate for inpatient hospital payments (scheduled for fiscal year 2018 under the American Taxpayer Relief Act of 2012) will instead be phased in at 0.5 percent per fiscal year, from 2018 through 2023.

TITLE V—MISCELLANEOUS

Subtitle A—Protecting the Integrity of Medicare

Sec. 501. Prohibition of inclusion of Social Security account numbers on Medicare cards.

The Secretary must achieve this by April 16, 2019, and will receive funding to carry it out.

Sec. 502. Preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals.

Requires the Secretary to establish new policies and claims edits to prevent these payments, and to report back to Congress by October 16, 2016, and periodically thereafter.

Sec. 503. Consideration of measures regarding Medicare beneficiary smart cards.

Directs the Secretary to explore the cost-effectiveness and technological viability of using smart cards as identification for Medicare beneficiaries and report back to Congressional committees.

Sec. 504. Modifying Medicare durable medical equipment face-to-face encounter documentation requirement.

Allows a physician assistant, nurse practitioner, or clinical nurse specialist to document their own face-to-face encounter with a patient, instead of requiring the physician who ordered the DME to document that this encounter occurred.

Sec. 505. Reducing improper Medicare payments.

Establishes a new Medicare Administrative Contractor (MAC) "Improper Payment Outreach and Education Program" that provides physicians and other providers a list of the most frequent and expensive payment errors; instructions on how to avoid or correct such errors; new topics approved for audits by recovery audit contractors (RACs); instructions on how to avoid issues related to those new topics; and other information as appropriate.

Sec. 506. Improving senior Medicare patrol and fraud reporting rewards.

By October 16, 2016, the Secretary must submit to Congress a plan to revise the incentive program to encourage reporting of fraud and abuse under the Health Insurance Portability and Accountability Act (HIPAA). Senior Medical Patrols will conduct a public awareness campaign to inform the public about the program.

Sec. 507. Requiring valid prescriber National Provider Identifiers on pharmacy claims.

Starting in 2016, claims for covered Part D drugs for a Part D-eligible beneficiary enrolled in a prescription drug or Medicare Advantage plan must include the prescriber's National Provider Identifier (NPI). Beneficiaries must be informed of the reasons for denial of any such claims. HIPAA requires that covered entities, including physicians, use NPIs in standard transactions. There has been ongoing concern that many Part D pharmacy claims have included an invalid NPI that, for example, does not correspond to the prescriber, has expired, or is for a deceased physician. Section 507 is designed to ensure that NPIs are correct to prevent fraudulent use of an NPI in the case of identity theft or where a prescriber's other identification (DEA number, for example) does not correspond to the NPI.

Sec. 508. Option to receive Medicare Summary Notice electronically.

Allows and encourages electronic delivery of Medicare Summary Notices by HHS, starting in 2016.

Sec. 509. Renewal of Medicare Administrative Contractor (MAC) contracts.

Lengthens the contract period, for future contracts, from 5 years to 10 years, and calls for making MAC performance available to the public to the extent possible without compromising the contract process.

Sec. 510. Study on pathway for incentives to States for State participation in Medicaid data match program.

Calls for a study by the Secretary and possible incentives, as appropriate.

Sec. 511. Guidance on application of Common Rule to clinical data registries.

By April 16, 2016, requires the Secretary to clarify whether the "Common Rule" (protecting human subjects in clinical research) applies to clinical data registries, including qualified clinical data registries.

Sec. 512. Eliminating certain civil money penalties; gainsharing study and report.

Limits the scope of monetary penalties to exclude inducements to physicians aimed at limiting non-medically necessary services. Requires a report from the Department of Health and Human Services on gainsharing.

Sec. 513. Modification of Medicare home health surety bond condition of participation requirement.

The bond must be at least $50,000.

Sec. 514. Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation.

Previously introduced in H.R. 1021, the "Protecting the Integrity of Medicare Act" (PIMA), this provision requires new oversight of Medicare coverage of certain chiropractor services (manual manipulation of the spine to correct subluxation), starting in January 2017. Prior authorization for treatment episodes with over 12 services will be required and will focus on chiropractors who either have aberrant billing patterns, or are in the 85th percentile for denial of claims. The Government Accountability Office will study (and submit a report to Congress by April 16, 2019) the effectiveness of this medical review. Section 514 also calls for education and training, in consultation with the American Chiropractic Association, to improve documentation to justify these services.

Sec. 515. National expansion of prior authorization model for repetitive scheduled non-emergent ambulance transport.

Expands the testing of this model to include all states in MAC regions that cover Delaware, the District of Columbia, Maryland, New Jersey, Pennsylvania, North Carolina, South Carolina, West Virginia, and Virginia, with the possibility of expanding the program nationally.

Sec. 516. Repealing duplicative Medicare secondary payor provision.

Technical amendment to section 1862(b)(5) of the Social Security Act.

Sec. 517. Plan for expanding data in annual CERT report.

By June 30, 2015, the Secretary must send a plan to congressional committees for including in the annual Comprehensive Error Testing Rate (CERT) report physician services paid at over $250 and with error rates above 20 percent.

Sec. 518. Removing funds for Medicare Improvement Fund added by IMPACT Act of 2014.

Takes away $195 million funded for this purpose.

Sec. 519. Rule of construction.

Preserves the right of notice and comment rulemaking in implementing Subtitle A of MACRA, except where explicitly provided otherwise.

Subtitle B—Other Provisions

Sec. 521. Extension of two-midnight PAMA rules on certain medical review activities.

Extends the Medicare Administrative Contractor (MAC) "probe and educate" program in the Protecting Access to Medicare Act through September 30, 2015.

Sec. 522. Requiring bid surety bonds and State licensure for entities submitting bids under the Medicare DMEPOS competitive acquisition program.

Requires suppliers of durable medical equipment (DME) to meet state licensure requirements for that product, and obtain a surety bond for each geographic area.

Sec. 523. Payment for global surgical packages.

Preserves the 10-day and 90-day global periods for over 4,000 surgical service codes, reversing a recently adopted rule by the Centers for Medicare & Medicaid Services (CMS) to unbundle these services. Beginning January 1, 2017, the Secretary must collect information to ensure the accuracy of the bundled payments, and may withhold portions of payments to incentivize reporting of information.

Sec. 524. Extension of Secure Rural Schools and Community Self-Determination Act of 2000.

Two-year extension of payments assisting counties affected by declining timber revenues for federal forests.

Sec. 525. Exclusion from PAYGO scorecards.

Allowed Congress to consider the bill without having to fully offset its entire cost.