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Summary of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), The "Doc Fix" Bill

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Following the House, last week the Senate passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and President Obama signed the bill into law. MACRA does away with Sustainable Growth Rate (SGR), a Balanced Budget Act of 1997 provision that the Congress failed to enforce (with one exception) by identifying other savings to offset Medicare reimbursement cuts to physicians. The SGR was generally vilified because it failed to address volume and intensity and lacked incentives to improve care quality and appropriateness. MACRA accomplishes several additional policy goals including extending the CHIP (Children's Health Insurance Program) for two years, extending several Medicare and Medicaid expiring provisions and provisions related to Medicare program integrity. MACRA also makes changes to inpatient hospital, post-acute, DSH (Disproportionate Share Hospital) reimbursement, so called Medigap insurance and Medicare Part B and D income-related beneficiary premiums, all to help partially offset the COB-estimated $175 billion legislation. Here, however, we will limit our comments to a summary MACRA Title I, or the provisions related to Medicare payment reform since these are specifically relevant to MSSP ACO providers. (For a thorough summary of MACRA see, for example, CRS's 70-page "H.R. 2: The Medicare Access and CHIP Reauthorization Act of 2015" by Jim Hahn and Kirstin Blom (April 10, 2015) at: http://fas.org/sgp/crs/misc/R43962.pdf.

2015-2019: It's Largely Status Quo

Beginning this calendar or performance year, 2015, and for the next four years, or through 2019, Medicare physicians through the Medicare physician fee schedule will receive a 0.5% annual update. (From 2020 to 2025 the payment update will be 0.0%. Beginning in 2026 the update for APM providers (discussed below) will be 0.75% per year. The update for those not participating as an APM will be 0.25%.) Between 2015 and 2019 all current Medicare incentive and penalty payments will remain in place. Payment bonuses and penalties via the Physician Quality Reporting Initiative (PQRI) will continue. Incentive payments to physicians via the adoption of HIT/EHR "meaningful use" will continue through 2016 while penalty reductions will continue through 2019. The Value-based Modifier (VM) program that began this year will continue through 2019. (The VM program will apply to MSSP ACO physicians beginning in 2017.)

2019-2024: Merit-Based Incentive Payment System (MIPS)

Beginning in 2019 a new incentive payment system, termed the Merit-Based Incentive Payment System (MIPS), will replace or sunset PQRI, HIT/EHR and the VM programs. MIPS will incent physicians and other eligible professionals including PAs, NPs, CNSs and certified registered nurse anesthetists. MIPS will use a new set of performance measures to calculate a composite score (between 0 and 100). The performance categories are:

- Quality: a set of quality measures
- Resource Use: measures of resource use established under the VM program and possibly as well Part D costs

- Clinical Practice Improvement Activities: these would include expanded practice access; population management; care coordination; beneficiary engagement; patient safety; and, participation in an alternative payment model (again, see below)
- Meaningful Use of Certified EHR Technology: or the requirements under current law

The specifics for each performance category will be established by the Secretary. Each category will be weighted: 30% for quality and resource use, 15% for clinical practice and 25% for EHR technology. However, the Secretary can choose to assign different scoring weights. Those eligible professionals that performed at the threshold would receive no payment adjustment. Those who exceeded the threshold would receive a positive adjustment and those that scored below the threshold a negative adjustment. The adjustment factor will begin at 4% (again, either positive or negative) in 2019, increase to 5% in 2020, to 7% in 2021 and to 9% in 2022 to 2024. For those that achieve exceptional performance, an additional bonus payment can be awarded as specified by the Secretary via a $500 million annual fund. Any additional adjustment for exceptional performance cannot exceed 10%. MIPS performance data would be made available to the public via in part the Physician Compare website. Finally, to improve the measurement of "resource use" the Secretary is required to develop new care episode and patient condition groups and classification codes, patient relationship categories and other codes.

Alternative to MIPS

Providers or eligible professionals can be rewarded an annual 5% bonus paid in a lump sum if they qualify as an "Alternative Payment Model (APM)." Providers qualifying or receiving a 5% APM bonus would not participate in the MIPS. To qualify as an APM a provider would have to use certified EHR technology, be reimbursed based in part on quality performance and would have to bear financial risk for monetary losses that are in excess of a nominal amount. In 2019 and 2020 this would mean a provider that has at least 25% of their payments via an APM and in 2021 and 2022 at least 50% of payments received via a Medicare APM or all payers. For 2023 and beyond the criteria is 75%. A Track 2 MSSP ACO would qualify as an APM but not a Track 1 ACO. In order to evaluate and advise the Secretary on APMs, specifically what kind of payment arrangement qualifies, an ad hoc "Physician-Focused Payment Models Technical Advisory Committee" will be formed by the end of 2015. Five of the advisory committee's eleven members would be providers or suppliers. By November 2016 the Secretary is required to establish through rulemaking criteria for APMs. The Secretary is also required by July 2016 to submit to the Congress a study examining the feasibility of integrating APMs in the MA payment system.

2025 and Beyond

In 2025 the 5% APM bonus and the $500 million in additional bonus payments for exceptional performance will expire. It's anticipated this would result as a payment reduction for most physicians which is why the CMS Office of the Actuary has stated additional offsets would be needed.

Summary

While MACRA effectively repeals the SGR what replaces it is largely TBD. How each MIPS performance category will be specifically defined, how each category will be weighted, and how exceptional performance will be defined are all unknown. Specific to quality measures, the legislation states providers or eligible professionals "may choose" what quality measures it will be measured against. How this is determined via rulemaking remains to be seen. Also too, what type of payment reimbursement models qualify as APMs is not decided nor how the 25-to-75 percent of payments necessary to qualify as an APM are defined.