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Medicare Access and CHIP Reauthorization Act

OVERVIEW

On April 14th, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (available here). The bill would permanently repeal the Sustainable Growth Rate (SGR) formula that perennially projects significant cuts to physician payments and replace it with a new payment formula. The bill also extends funding for the Children's Health Insurance Program (CHIP) and makes other changes to Medicare.

PHYSICIAN PAYMENTS

The bill repeals the SGR and provides physicians and other professionals with 0.5 percent annual payment increases from 2015 to 2019.

Rates will be held at 2019-levels through 2025. Physicians and other professionals will have the opportunity to receive additional payment adjustments through a consolidated incentive payment program, described below.

In 2026 and subsequent years, physicians and other professionals participating in alternative payment models (APMs) that meet certain criteria will receive annual updates of 0.75 percent, while all others would receive annual updates of 0.25 percent.

The Medicare Payment Advisory Commission (MedPAC) is required to submit reports to Congress in 2019 evaluating the impact that the 2015-2019 updates have on beneficiary access and quality of care, with recommendations regarding further updates. Further, MedPAC will submit reports to Congress in 2017 and 2021 that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D.

Merit-Based Incentive Payment System

The incentive payment program, referred to as the Merit-Based Incentive Payment System (MIPS), consolidates three existing incentive programs:

- Physician Quality Reporting System (PQRS);
- The Value-Based Modifier (VBM); and
- Medicare EHR Incentive Program.

The existing programs will sunset at the end of 2018.

Eligible Professionals

Beginning in 2019, the MIPS will apply to: doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021.

Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible alternative payment models, will be excluded from the MIPS.

Performance Measurement

The MIPS will assess the performance of eligible professionals in four categories:

- **Quality**. Measures used for this performance category will be published annually. In addition to measures used in the existing quality performance programs, the Secretary would solicit recommended measures and fund professional organizations and others to develop additional measures.
- **Resource Use.** The resource use category will include measures used in the current VBM program.
- **Meaningful Use.** Current EHR Meaningful Use requirements will continue to apply in order to receive credit in this category.
- **Clinical Practice Improvement Activities.** Professionals will be assessed on their effort to engage in clinical practice improvement activities. The menu of recognized activities will be established in collaboration with professional associations and societies.

Professionals will receive a composite performance score of 0-100 based on their performance in each of the four performance categories listed above. Each eligible professional's composite score will be compared to a performance threshold. The performance threshold will be the mean or median of the composite performance scores for all MIPS eligible professionals during a period prior to the performance period.

Payment Adjustments

Eligible professionals whose composite performance scores fall above the threshold will receive positive payment adjustments and eligible professionals whose composite performance scores fall below the threshold will receive negative payment adjustments. The payment adjustments will be budget neutral; the negative payment adjustments will fund positive payment adjustments.

Negative payment adjustments will be capped at 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022. Positive payment adjustments will be capped at a maximum of 3 times the annual cap for negative payment adjustments.

Additional positive payment adjustments will be made for exceptional performance. Incentive payments for exceptional performance will be capped at $500 million per year for each of 2019 through 2024.

Alternative Payment Models

Professionals who receive a significant share of their revenues through an APM that involves down-side risk and a quality measurement component, or a patient-centered medical home, will receive a five percent bonus each year from 2019-2024. Two tracks will be available for professionals to qualify for the bonus:

- The first option will be based on receiving a significant percentage of Medicare revenue through an APM.
- The second will be based on receiving a significant percentage of APM revenue combined from Medicare and other payers. This option makes it possible for professionals to qualify for the bonus even if Medicare APM options are unavailable in their area. If no Medicaid APM is available in a state, a professional's Medicaid revenue will not be counted against the proportion of revenue in an APM.

Professionals who meet these criteria will be excluded from the MIPS assessment and most EHR meaningful use requirements. The Secretary is specifically encouraged to test APMs relevant to specialty professionals, professionals in small practices, and those that align with private and state-based payer initiatives.

CHIP EXTENSION

Prior to this legislation, while the CHIP program was authorized through 2019, funding was set to expire at the end of FY 2015. The bill extends funding for CHIP for two years, through FY 2017.

The bill also extends funding for certain CHIP-related programs as well. Funding for the Express Lane Eligibility (ELE) program is extended through FY 2017. ELE permits states to rely on findings from other agencies and program for measures like income, household size, or other factors of eligibility, to facilitate enrollment in health coverage. ELE agencies and programs include SNAP, School Lunch, TANF, and Head Start. The bill also extends funding for the CHIP Outreach and Enrollment Program, which helps states identify children that are eligible for CHIP or Medicaid coverage, through FY 2017.

OTHER MEDICARE PROVISIONS

Continued Delay of Two-Midnights Enforcement

Per CMS regulation, the two-midnight policy requires a patient stay of two midnights in a hospital to qualify for inpatient status in most instances; shorter stays will be paid as an outpatient visit. Though the policy has been in effect since October 1, 2013, enforcement of its provisions through audits and penalties have been delayed. Instead CMS has undertaken the Medicare Administrative Contractor (MAC) "probe and educate" program to assess provider understanding and compliance with the two-midnight rule. Previously set to expire May 1, 2015, the bill instructs CMS to continue use of the "probe and educate" approach through September 30, 2015.

Medicare Extenders

Several Medicare provisions, such as the work Geographic Practice Cost Index floor, therapy cap exceptions process, ambulance add-ons, low-volume hospital payments, and Medicare-dependent hospitals, expired on April 1, 2015. The bill will extend those increases through the end of either FY 2017 or calendar year 2017.

Medicare Advantage Special Needs Plan (SNP) Extension

The bill extends authority for SNPs through December 31, 2018.

Bundled Payments for Surgical Services

The bill reverses the CMS decision to eliminate the bundled payment for surgical services that span a 10-day and 90-day period. It requires CMS to periodically collect information on the services that surgeons furnish during these global periods beginning not later than 2017 and use that information to ensure that the bundled payment amounts for surgical services are accurate.

OFFSETS

Approximately $73 billion of the $214 billion bill is paid for. Offsets include:

Medigap

The bill requires that, beginning in 2020, new Medigap plans eliminate first-dollar coverage. Plans will be allowed to cover costs above the amount of the Part B deductible (currently $147 per year).

Means-Testing in Medicare Parts B and D

Beginning in 2018, Medicare Part B and D premiums will increase for beneficiaries making more than $133,501. Beneficiaries with modified adjusted gross income (MAGI) between $133,501 and $160,000 ($267,001-$320,000 for a couple) will now pay 65 percent of premiums, up from 50 percent. Beneficiaries that earn $160,001 and above ($320,001 and above for a couple) would pay 80 percent of the premiums.

Additionally, current law freezes the income thresholds through 2019, at which point the income thresholds would be indexed to inflation as if they had not been frozen. Starting in 2020, this policy would update the threshold for inflation based on where they were in 2019.

Post-Acute Provider Payments

In FY 2018, the Medicare market basket update for post-acute care providers will be capped at 1 percent.

Medicaid Disproportionate Share Hospital (DSH)

Currently, reductions in state DSH allotments are scheduled to begin in FY 2017. The bill will delay Medicaid DSH cuts until FY 2018, but add an additional year of cuts in 2025.

Hospital Inpatient Payment Rate Adjustments

From FY 2018 to 2023, annual payment rate increases for hospital inpatient services will be capped at 0.5 percent for the next six years. This would eliminate the one-time 3.2 percent increase that is scheduled for FY 2018.

Levy on Medicare Providers for Nonpayment of Taxes

Under current law, the Department of the Treasury may impose a levy of up to 30 percent against Medicare service providers with tax delinquencies. The bill will permit the Treasury to impose a levy of up to 100 percent on tax delinquent Medicare service providers.