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

2015

- The MACRA was signed into law by President Obama on April 16, 2015.
- The Medicare Sustainable Growth Rate (SGR) formula is permanently repealed.
- In lieu of scheduled 21 percent SGR cut for 2015, MACRA provides updates of:
    - 0 percent through June 2015; and
    - 0.5 percent in July 2015 through December 2019.
- Over 4,000 surgical service codes retain their 10-day and 90-day global periods.
- Provisions of the "Standard of Care Protection Act" prevent quality programs from setting "standards of care" in medical liability actions.
- The MACRA provides quality measure development funding of $15 million per fiscal year, FY 2015 to FY 2019, from Medicare Trust Fund.
- Physicians may opt out of Medicare on a continuous basis, without having to renew their status every two years.
- Members will be appointed to the Physician-Focused Payment Model Technical Advisory Committee, which evaluates alternative payment models (APMs).
- Non-physicians may document their own face-to-face patient encounter under Medicare requirements for durable medical equipment (DME).

2016

- The MACRA provides technical assistance funding of $20 million per fiscal years, FY 2016 to FY 2020, to assist small practices (up to 15 professionals) to participate in APMs and the new Merit-Based Incentive Payment System (MIPS) program.
- Physician groups (as well as individuals) may report quality measures for the Physician Quality Reporting System (PQRS) via qualified clinical data registries (QCDRs).
- A new "Measure Development Plan" sets priorities for new quality measures for MIPS and APM quality reporting.
- Medicare Part D claims must include the prescriber's NPI number.
- Information blocking by Meaningful Use (MU) professionals and hospitals is prohibited.
- The Secretary of HHS must clarify how the "Common Rule," that protects research subjects, applies to clinical data registries, including QCDRs.
- Qualified entities and QCDRs may have access to Medicare claims data.
- The Secretary sets criteria for physician-focused payment models.
- The annual list of MIPS quality measures is due by November 1 of each year.
- The IRS may collect up to 100 percent of Medicare payments due to overdue taxes.

2017

- The Secretary begins collecting data on the accuracy of global service packages.
- All physicians are subject to payment adjustments (bonuses or penalties) for their resource use under the Value-Based Payment Modifier (VBM).
- Many federal programs are funded through FY 2017 (September 30, 2017) including the Children's Health Insurance Program (CHIP), Teaching Health Center GME Payment Program, community health centers, and Medicare-dependent hospitals (MDHs).

2018

- Medicare claims must identify the care episode, patient condition, and patient relationship, to attribute resource use to the appropriate physician or other eligible professional (EP) under the MIPS program.
- Higher income beneficiaries begin paying higher premiums under Parts B and D.
- Separate PQRS, MU, and VBM reporting and penalties sunset on December 31, 2018.
- The MACRA sets a goal of achieving interoperability of EHR systems by the end of 2018 and allows penalties and other consequences if this does not occur.
- The Secretary must inform each physician (and other EP) of their upcoming MIPS payment adjustment, at least 30 days in advance.
- A 3.2 percent increase in the base rate for inpatient hospital payments (scheduled for FY 2018 under the American Taxpayer Relief Act of 2012) will instead be phased in at 0.5 percent per fiscal year, from FY 2018 through FY 2023.
- The 2018 post-acute care update is limited to one percent (for skilled nursing and inpatient rehabilitation facilities, home health, hospice, and long-term care hospitals).

2019

- The MIPS program takes effect, consolidating and replacing PQRS, MU, and the VBM.
    - Annual MIPS composite scores include four categories: quality (PQRS) – 30 percent; resource use (VBM) – 30 percent; MU – 25 percent; and clinical practice improvement activities – 15 percent.
    - The annual "performance threshold" is based on the median/mean performance of all EPs for a prior period.
    - The Secretary may weight the categories differently.
    - Individual EPs can join "virtual groups" and report together.
    - EPs with substantial revenue from qualifying APMs or with few Medicare claims are exempt from the MIPS program.
    - MIPS EPs include physicians, dentists, podiatrists, optometrists, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists.
- MIPS penalties and bonuses (for scores below or above the annual performance threshold) are on a sliding scale, with maximum MIPS penalties:
    - Up to 4 percent in 2019;
    - Up to 5 percent in 2020;
    - Up to 7 percent in 2021; and
    - Up to 9 percent in 2022 and beyond.

    - MIPS bonuses can go even higher (up to 3 times these levels). But total MIPS bonuses and penalties must balance each other.
- An extra "exceptional performance" bonus of up to 10 percent is available from 2019 through 2024, up to $500 million each year.
- Physicians and other EPs with substantial revenue from qualifying APMs receive a 5 percent bonus payment in 2019 through 2024.
- MedPAC recommends future payment updates to Congress in its annual report.

2020

- The payment update under MACRA for 2020 through 2025 is 0 percent, subject to further action by Congress (pursuant to recommendations by MedPAC).
- Medigap plans for new enrollees may not offer "first dollar" coverage; beneficiaries must pay at least the Part B deductible (currently $147 per month).

2021

- The Secretary may expand the MIPS program to social workers, psychologists, dietitians, nutritionists, physical and occupational therapists, speech pathologists, and audiologists.
- Medigap plans for new enrollees may not offer "first dollar" coverage. Beneficiaries must pay at least the Part B deductible (currently $147 per month).

2026 and Beyond

- The payment update under MACRA for 2026 and beyond is 0.75 percent for qualifying APM participants and 0.25 percent for all others, subject to further action by Congress (pursuant to recommendations by MedPAC).