

The Medicare Access and CHIP Reauthorization Act (MACRA) – P.L. 114-10

Section-by-Section Summary: This summary was developed by ASCRS to inform members of specific provisions of the bill relevant to our members and their practices. Please refer to additional summaries or the legislative text posted on ASCRS' website for information about other provisions included in the law.

Sec. 1. Short title, table of contents

Sec 2. Repealing the Sustainable Growth Rate (SGR) and Improving Medicare Payment for Physicians' Services

Stabilizing Fee Updates

This section repeals the SGR and prevents the 21% cut that was scheduled to go into effect April 1, 2015. Physicians will receive an annual update of 0.5% in each of the years 2015 through 2019. The fee schedule update will go into effect July 1, 2015. Subsequent year updates will go into effect on January 1. There will be a 0% update for 2020 through 2025. For 2026 and beyond, physicians remaining in fee-for-service receive a 0.25% annual update, while alternative payment model (APM) participants receive a 0.75% update.

Consolidating Current Law Programs into a Unified Merit-Based Incentive Payment System (MIPS)

Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2019. The MIPS streamlines the three current quality reporting programs: the Physician Quality Reporting Program (PQRS), the Value-Based Payment Modifier (VBPM) and EHR/Meaningful Use – and adds a section on clinical practice improvement activities.

Sun setting Current Law Incentive Program Penalties

Penalties associated with the current quality programs are sunset at the end of 2018—including the 2% penalty for failure to report PQRS quality measures and 3% penalty for failure to meet Meaningful Use. The money from penalties that would have been assessed now remains in the physician fee schedule.

Professionals to Whom MIPS Applies

MIPS applies 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 beginning in 2019. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, provided there are viable performance metrics available. Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible alternative payment methods (APMs), will be excluded from the MIPS.

MIPS Assessment Categories

MIPS will assess the performance of eligible professionals based on four categories: quality, resource use, meaningful use and clinical practice improvement activities. The quality category will include both current quality performance measures and new measures developed through annual rulemaking. Resource use determination will include measures used in the current Value-Based Payment Modifier program. Current meaningful use requirements will continue to apply for the meaningful use category.

Finally, professionals will be assessed on their effort to engage in clinical practice improvement activities.

Annual List of Quality Measures Used in MIPS

Through the annual rulemaking process, the Secretary will publish a list of quality measures to be used in the forthcoming MIPS performance period. Updates and modifications to the list of quality measures will also occur through this process. Eligible professionals will report and be assessed on measures they select. Eligible professional organizations and other relevant stakeholders will identify and submit quality measures to be considered for selection and to identify and submit updates to the measures already on the list.

Composite Performance Score

Eligible professionals will receive a composite score of zero to one hundred based on their performance in the four aforementioned categories. Each eligible professional's composite score will be compared to a performance threshold, which will be the mean or median of all composite performance scores for all MIPS eligible professionals during a prior period.

MIPS Payment Adjustment

Eligible professionals will receive a positive, negative, or neutral payment adjustment based on their composite score. The **negative adjustment** will be capped at four percent in 2019, five percent in 2020, seven percent in 2021 and nine percent in 2022. Eligible professionals that fall between zero and one-fourth of the threshold will receive the maximum negative penalty. Providers whose scores are closer to the threshold score will receive smaller negative payment adjustments.

If an eligible professional's composite score is at the threshold, they will not receive a MIPS payment adjustment. Eligible professionals with composite scores above the threshold will receive **positive payment adjustments**. The higher performance scores will receive proportionally larger incentive payments up to three times the annual cap for negative payment adjustments each year.

Beginning in 2019, MIPS participants can earn a 4% bonus with the potential to receive as much as three times the penalty cap amount for the year, in addition to a 10% in bonus for "exceptional" performers. Penalties for 2019 are capped at -4%. Bonus and penalty levels increase for the years following 2019 with a 15% bonus and -5% penalty for 2020 and a 21% bonus and -7% penalty in 2021.

Expanded Participation Options and Tools to Enable Success

Physicians have the flexibility to participate in MIPS in a way that best fits their practice. Technical assistance will be available to assist physicians in improving MIPS performance with priority given to practices with low MIPS scores or located in rural or underserved communities. \$20 million is available annually to fund technical assistance.

Encouraging Participation in Alternative Payment Models (APMs)

Professionals who receive a significant share of their revenues through an APM that involves risk of financial losses and a quality measurement component will receive a 5% bonus each year from 2019-2024. Professionals who receive at least 25% of their revenues from an APM in 2019 and 2020 will be exempt from MIPS. The Secretary is also instructed to develop proposals for APMs that are relevant to small or specialty practices.

Sec. 3: Priorities and Funding for Quality Measure Development

Measure Development Plan

Funding is provided and the Secretary is instructed to develop—with stakeholder input—a plan for the development of quality measures for use in the MIPS and APMs. The plan must prioritize outcome measures, patient experience measures, care coordination measures, measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings. The plan must be finalized by May 1, 2016.

Sec. 5: Empowering Beneficiary Choices through Access to Information on Physician Services

Beginning in 2015, in addition to the quality and resource use information that would be posted through the MIPS, the Secretary is required to publish utilization and payment data for physicians and professionals, as appropriate. With emphasis on the services a professional most commonly furnishes, such information will include the number of services furnished and submitted charges and payments for such services and will be searchable by at least the eligible professional's name, location, and services furnished. The Secretary will integrate this information on the Physician Compare website starting in 2016.

Sec. 6: Expanding Claims Data Availability to Improve Care

Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities or in developing APMs. The Secretary is also required to make data available to qualified clinical data registries to support quality improvement and patient safety activities.

Sec. 7: Reducing Administrative Burden and Other Provisions

Liability Protection

The development, recognition, or implementation of any guideline or other standard under any federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim. This ensures that MIPS participation cannot be used in liability cases. This provision would not preempt any state or common law governing medical professional or medical product liability actions or claims. This provision is intended to reaffirm existing law with respect to medical malpractice and medical products cases.

Additional Provisions

- Professionals who opt-out of Medicare may automatically renew every two years.
- Provides for regular reporting of opt-out physician characteristics
- Requires EHR interoperability by 2018 and prohibits data-blocking.

Sec. 523: Payment for Global Surgical Packages

This provision prevents CMS from proceeding with its policy to transition all 10- and 90-day global codes to 0-day codes. This would have had the greatest negative impact on ophthalmology, compared to all specialties.