

## **Myths and Facts about the Medicare Access and CHIP Reauthorization Act (MACRA)**

**MYTH: MACRA mandates physician participation in Maintenance of Certification (MOC).**

**FALSE:** There is nothing in the law mandating MOC, nor does it penalize physicians for not participating in MOC.

**MYTH: MIPS quality standards to be based solely on input from certification boards, such as the American Board of Medical Specialties (ABMS).**

**FALSE:** In fact, MACRA requires that the Secretary of Health and Human Services (HHS) get input from a wide variety of stakeholders on the selection of quality measures, including “relevant eligible professional organizations and other relevant stakeholders, including state and national medical societies.” In addition, MACRA lists “clinical or surgical checklists and practice assessments related to maintaining certification” (not the maintenance of certification itself) as just one of the examples of the type of clinical practice improvement activities for the required category of “patient safety and practice assessment” activities. However, there are five categories to choose from, and the Secretary can add more categories, in consultation with “stakeholders.”

**MYTH: MACRA will eliminate fee-for-service.**

**FALSE:** MACRA preserves the fee-for-service option and stipulates that participation in alternative payment models (APMs) is voluntary. Physicians opting to remain in fee-for-service must participate in the MIPS program; in 2019 and 2020 physicians participating in APMs who receive at least 25% of revenues from the APM are exempt from MIPS.

**MYTH: MACRA allows the Secretary of Health and Human Services (HHS) to punish physicians who opt out of Medicare.**

**FALSE.** The Secretary of HHS cannot selectively punish a physician because of his/her opt-out status.

**MYTH: Section 507 of MACRA bans physicians who opt out of Medicare from writing prescriptions under the Part D program.**

**FALSE.** Under current regulations, physicians who opt out of the Medicare program can still write prescriptions under the Medicare Part D program for covered beneficiaries, assuming they have filed an opt-out affidavit as required under existing law. In general, most practicing physicians are required to have a valid National Provider Identifier (NPI)—a requirement that is not limited to those who participate in the Medicare program, but includes those who opt out as well. The purpose of the NPI is to uniquely identify a health care provider in standard transactions, such as health care claims. NPIs may also be used to identify health care providers on prescriptions, in coordination of benefits between health plans, in patient medical record systems, in program integrity files, and in other ways. The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, including physicians, use NPIs in standard transactions. There has been an ongoing concern that the NPIs placed on Part D pharmacy claims have included invalid NPI claims—these could include NPIs that do not actually correspond to the prescriber, are expired NPIs, or are NPIs for deceased physicians, for example. 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.

**MYTH: MACRA creates new authority for the government to place a levy on Medicare payments if providers are delinquent on their taxes.**

**FALSE.** The Federal Payment Levy Program (FPLP) was first authorized under the Taxpayer Relief Act of 1997. This law allows the government to collect overdue taxes through a levy on certain federal payments (e.g., federal employee retirement annuities, contractors/vendors doing business with the government, certain Social Security benefits), including Medicare provider and supplier payments. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 expanded the FPLP to include a levy against Medicare payments for non-tax debt. Under MIPPA, CMS could have reduced federal payments subject to the levy by 15 percent until the overdue taxes were paid in full, and could have reduced federal payments subject to a non-tax levy by 100 percent or the amount of the non-tax debt owed. The Tax Increase Prevention Act of 2014 made further amendments to increase the levy rate from 15 percent to 30 percent on payments due to a Medicare provider or supplier for overdue taxes. H.R. 2 would increase the existing levy rate from 30 percent to 100 percent.