EHRA Summary
H.R.2 - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
SGR Repeal and Medicare Provider Payment Modernization

Following is the EHRA's summary and comments on MACRA, which prescribes significant changes to Medicare physician reimbursement over the next decade and beyond, including:

1. Permanently repeals the sustainable growth rate (SGR) reimbursement formula.
2. Establishes a stable period of annual reimbursement updates of 0.5 % for 2015 through 2019; the 2020 rate is to be constant through 2025.
3. Encourages physicians to adopt alternative payment models (APMs) with a 5% annual lump sum incentive payment prescribed for 2019 and through 2024.
4. Consolidate previous Medicare incentive payments into one program that rewards performance based on value and improvement. Beginning in 2026, payment rates will be updated either by 0.25% annually for providers participating in the **Merit-Based Incentive Payment System (MIPS)** or by 0.75% annually for providers participating in Alternative Payment Models. Physicians who receive a significant share of their revenue from dual-sided risk models can opt of participation in MIPS.
5. MIPS is set to begin in 2019 and includes:
    a. Physician Quality Reporting System (PQRS).
    b. Value-Based Modifier (VBM).
    c. Electronic Health Record Meaningful Use program (MU). The current penalties for these programs will end with 2018.
6. MIPS will include four categories of weighted "performance assessment" including quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities as follows:
    a. Quality measures (30 %) based on existing measurement programs in addition to other potential measure eligibility pathways. The Secretary of Health and Human Services is authorized to fund professional organizations to develop additional measures.
    b. Resource use (30%) based on the current VBM system with modifications.
    c. Meaningful use of electronic health records requirements (25%) based on the current meaningful use program.
    d. Clinical practice improvement activities (CPIAs, 15%) that foster future participation in APMs will be established by the Secretary.
7. Payment adjustments will be based on a physician's relative score above or below average thresholds established each year as follows:

Performance Year	Payment Year	Maximum Negative Adjustment	Maximum Positive Adjustment
2017	2019	-4%	+12%
2018	2020	-5%	+15%

2019	2021	-7%	+21%
2020 +	2022 +	-9%	+27%

8. Prescribes $20 million in annual funding ($100m total) for small-practice MIPS implementation, as well as technical assistance for transition to alternative payment models.
9. Authorizes the Secretary to determine if professionals have to qualify because they do not exceed a low-volume beneficiary threshold.
10. Provides $7 billion in funding over two years for community health centers, maintaining the current funding for community health centers that is set to expire on October 1, 2015.
11. Directs the Secretary to study: (1) the feasibility of integrating APMs into the Medicare Advantage payment system; and (2) the applicability of federal fraud prevention laws to items and services paid for under an APM.

Key Take-Aways:

- *Many physician groups have long detested the SRG formula, which linked Medicare payment increases to increases in the gross domestic product and typically threatened large payment cuts for physicians. The cuts were avoided by a series of 17 "patches" passed by Congress over the last 12 years in place of actual reform. The vote on Tuesday staved off a 21 percent reduction in Medicare payments to physicians, which would have gone into effect today. The bill replaces physicians' mandatory participation in the Value-Based Payment Program under Medicare with this new Merit-based Incentive Payment System (MIPS).*
- *The measure also consolidates various reporting programs, such as the "meaningful use" EHR Incentive Program and several quality reporting programs, into a new merit-based incentive payment system and would incentivize physicians to participate in alternative payment models such as accountable care organizations (ACOs).*
- *The AMA reports that the legislation outlines several provisions that should be beneficial for physicians, including:*
    - *Protections are included so that medical liability cases cannot use Medicare quality program standards and measures as a standard or duty of care.*
    - *Incentive payments will be available for physicians who participate in alternative payment models and meet certain thresholds.*
    - *Technical support will be provided to help smaller practices participate in alternative payment models or the new fee-for-service incentive program.*
- *Bottom line:*
    - *Physicians like this legislation because it relieves them of the threat of ongoing reimbursement cuts and provides support for participation in APMs.*

Provisions Related to Information and Health Information Technology

1. Directs the Secretary to make publicly available annually information on items and services furnished to Medicare beneficiaries by physicians and other eligible professionals. (Sec. 104).
2. The Medicare Meaningful Use EHR Incentive Program will continue as currently structured through 2018 and then will be incorporated into MIPS.
3. Expands the kinds of uses of Medicare data available to qualified entities for quality improvement activities. Directs the Secretary to provide Medicare data to qualified clinical data registries to facilitate quality improvement or patient safety. (Sec. 105)
4. Declares it a national objective to achieve widespread exchange of health information through

interoperable certified electronic health records technology (CEHRT) nationwide by December 31, 2018. Directs the Secretary to establish related metrics. (Sec. 106)

5. Requires the Secretary to examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products.
6. Directs GAO to study specified telehealth and remote patient monitoring services.

Key Take-Aways

- *Meaningful use incentives are rolled into MIPS so will be perpetuated through various quality reporting and payment programs so associated certification of EHRs will continue and be broadened to other health IT.*
- *Health IT will be central to collecting and reporting quality data to clinical data registries.*
- *Interoperability of CEHRT is now law and required by December 2018, but specifics are to be determined through a report from HHS and follow-on regulation.*
- *HHS will consider establishing some sort of CEHRT comparison mechanism to help providers compare and select EHRs and other health IT.*

Other provisions Related to Medicare Extenders

1. Directs the Secretary to draft a plan for development of quality measures to assess professionals, including non-patient-facing professionals. (Sec. 102)
2. Directs the Secretary to make payments for chronic care management services furnished by a physician, physician assistant or nurse practitioner, clinical nurse specialist, or certified nurse midwife. (Sec. 103)
3. Other provisions of the MACRA can be viewed here - H.R.2 - Medicare Access and CHIP Reauthorization Act of 2015.

Key Take-Aways

- *Expect continued expansion of quality measures (i.e., all the complexities around development, testing tools, and reporting) to include non-patient facing professionals, as well as clinicians who deliver chronic care management services who will also now be reimbursed under Medicare.*

Funding

About one-third of the measure's $200 billion-plus cost of the SGR permanent replacement bill will be offset. The two-thirds will be added to the federal deficit. The funding offsets will be approximately evenly shared between providers and beneficiaries.

Beneficiaries –

1. The bill will increase the share of premiums for high-income beneficiaries; beneficiaries with incomes between $133,500 and $160,000 premiums will increase from 50% to 65% and with incomes between $160,000 and $214,000, premiums will increase from 65% to 75%.
2. Medigap plans with no Part B deductible for beneficiaries who become eligible in 2020 and beyond will be phased out.

Providers –

1. Extends cuts through 2025 to the disproportionate share hospital program that originally in the Affordable Care Act.
2. Alters reimbursement rates that to post-acute providers, including skilled-nursing facilities and hospice providers beginning in 2018.

3. Authorizes withholding of 100% of providers' delinquent taxes from their Medicare reimbursements.
4. Extends 3.2% increase in Medicare hospital reimbursements to take effect in 2018 over six years.
5. Restricts scheduled reimbursement increases for home health providers, hospices and nursing homes to 1%.

Key Take-Aways

- *No direct impact on EHRs and health IT, but some providers will see reduced reimbursement while others may see increasing reimbursement.*

Conclusion

Enactment of the Medicare Access and CHIP Reauthorization Act (H.R. 2) permanently replaces the Medicare sustainable growth rate (SGR) formula and also takes important steps toward using health IT to support quality improvement and help align quality reporting programs as a means of reducing the reporting burden on the provider community.

The SGR Repeal also includes important provisions to enhance interoperability and telehealth utilization, both critical capabilities necessary for moving forward with healthcare transformation. Next steps must include:

- Facilitate core interoperability through development and implementation of nationwide agreed-upon data and transmissions standards.
- Harmonize quality reporting standards.
- Enhance privacy and security.
- Improve patient safety, including as recommended in the April 2014 "*FDASIA Health IT Report"* prepared by the ONC, FDA, and FCC.

While there will still be a place for fee-for-service in the future, physicians will have the opportunity to be rewarded for continuous quality improvement. The legislation encourages physician practices to move into integrated team-based practices including medical homes and patient-focused and coordinated health care focused on outcomes. This legislation will also encourage evidence-based clinical practice guidelines will be an important change whose time has come. Importantly the bill attempts to provide for transition and stability during the transition.

H.R. 2 will help focus on improving system-wide efficiencies such as payment reforms, interoperability, and quality of care reporting. CMS will now engage in a process of formal rule making that will likely take between now and 2018.