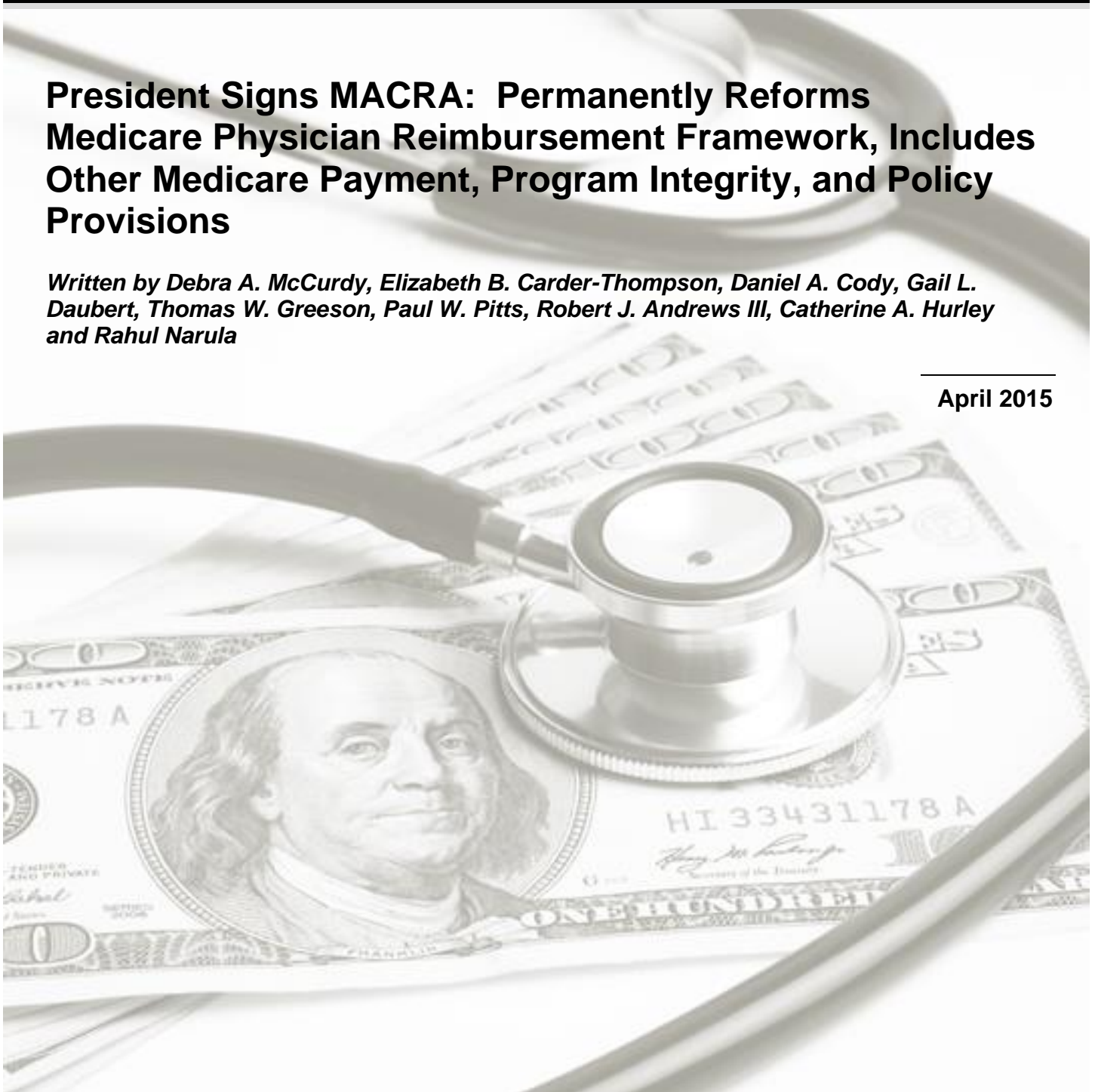


President Signs MACRA: Permanently Reforms Medicare Physician Reimbursement Framework, Includes Other Medicare Payment, Program Integrity, and Policy Provisions

Written by Debra A. McCurdy, Elizabeth B. Carder-Thompson, Daniel A. Cody, Gail L. Daubert, Thomas W. Greeson, Paul W. Pitts, Robert J. Andrews III, Catherine A. Hurley and Rahul Narula

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On April 16, 2015, President Obama signed into law H.R. 2, the “Medicare Access and CHIP Reauthorization Act of 2015” (MACRA), which reforms Medicare payment policy for physician services and adopts a series of policy changes affecting a wide range of providers and suppliers.¹

Most notably, MACRA permanently repeals the statutory Sustainable Growth Rate (SGR) formula, achieving a goal that has eluded Congress for years. This step overrides a 21.2 percent across-the-board cut in Medicare physician payments that briefly took effect April 1, 2015, and ends a long cycle of Medicare physician fee schedule (MPFS) cuts being triggered automatically and Congress then responding with temporary patches. Instead, after a period of stable payment updates, MACRA will link physician payment updates to quality, value measurements, and participation in alternative payment models. MACRA also extends certain expiring Medicare and other health policy provisions, including a two-year extension of the Children’s Health Insurance Program (CHIP).²

To finance these provisions, MACRA reduces market basket updates for post-acute care providers, revises inpatient hospital payment rate updates, restructures Medicaid disproportionate share hospital (DSH) reductions, imposes additional income-related adjustments for Medicare Part B and Part D premiums, and bars first-dollar Medigap coverage policies. Finally, MACRA includes a number of policy provisions, including: new program integrity policies; a binding bid requirement under the durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program; an additional delay in enforcement of the “two midnight” hospital inpatient status policy; and revisions to payment for global surgical packages.

This *Client Alert* summarizes the major Medicare and Medicaid provisions of MACRA, focusing on those provisions we believe to be of most interest to our clients. We would be pleased to provide additional details upon request.

¹ The text of MACRA is available at <https://www.congress.gov/bill/114th-congress/house-bill/2/text>.

² On the other hand, MACRA does not extend the timeframe for implementation of the ICD-10 code set beyond October 1, 2015, despite earlier speculation that the legislation would be a vehicle to once again push back this deadline.

I. SGR Repeal and Payment Modernization

The SGR formula was established by the Balanced Budget Act of 1997 as a means to control Medicare spending on physician services. In short, the SGR formula reduces Medicare payments to physicians if spending growth exceeds a target spending rate based on a number of factors, including overall growth in costs, Medicare enrollment, and volume of service.

Over the past decade, concerns have escalated that the formula penalizes physicians for factors largely beyond their control, such as increased demand, and is indiscriminate in cutting payment to both efficient and inefficient providers. Since 2002, the formula has annually called for reimbursement cuts, ranging from -3.3 percent to -26.5 percent, which Congress has repeatedly overridden on a short-term basis (except in 2002, when a 4.8 percent cut went into effect).³ The latest patch, included in the Protecting Access to Medicare Act of 2014 (PAMA), replaced a 21.2 percent across-the-board SGR cut for 2015 with a freeze, but only through March 31, 2015.

MACRA repeals the SGR formula effective for services provided on or after January 1, 2015, and establishes a new payment framework consisting of stable fee schedule updates, a new Merit-Based Incentive Payment System (MIPS), and incentives for participation in alternative payment models (APMs).

A. Annual Fee Schedule Updates

MACRA establishes the following fee schedule conversion factor updates:

- **January 1 through June 30, 2015:** 0 percent update (overlapping the PAMA freeze that ran until March 31, 2015)
- **July 1, 2015 through December 31, 2015:** 0.5 percent update
- **2016 through 2019:** 0.5 percent update each year (subject to MIPS adjustment beginning in 2019)
- **2020 – 2025:** 0.0 percent update each year (subject to MIPS and APM adjustment)
- **2026 and Subsequent Years:** There are two separate annual updates: (1) a “qualifying APM conversion factor” for professionals participating in qualified APMs (defined below), set at 0.75 percent, and (2) a “nonqualifying APM conversion factor” for all other professionals, set at 0.25 percent.

³ For a detailed discussion of the history of the SGR and the Congressional response, see the Congressional Research Service brief, “Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System,” available at http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/R40907_gb.pdf.

MACRA mandates certain Medicare Payment Advisory Commission (MedPAC) reports related to the physician payments, including a report on the effect of the payment update on efficiency, quality of care, and physician participation.

B. Merit-Based Incentive Payment System

As noted, MACRA requires the Secretary of Health and Human Services (HHS) to establish an eligible professional MIPS under which a provider's performance is assessed according to established performance standards and used to determine an adjustment factor that is then applied to the professional's payment for a year. The MIPS will apply to items and services furnished on or after January 1, 2019. The MIPS provisions are extensive and technical; the major features of the program are noted below.

1. Consolidation of Certain Current Performance Programs

The MIPS will consolidate the following current Medicare incentive programs: the Electronic Health Record (EHR) Meaningful Use Incentive Program, the Physician Quality Reporting System (PQRS), and the Value-Based Modifier (VBM). The existing programs continue through the end of 2018, when they sunset (although certain current measures and standards will be applied to the new MIPS program).

2. MIPS Eligible Professionals

For the first two years, the MIPS applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, as well as group practices including such professionals. In subsequent years, the Secretary may include other eligible professionals. A MIPS eligible professional does *not* include qualifying or certain partial-qualifying APM participants (discussed below), or professionals who do not exceed a low-volume threshold measure.

3. Performance Categories and Measures

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

- a. Quality:** Includes measures used in the existing quality performance programs, in addition to new measures developed through notice and comment rulemaking, and measures used by qualified clinical data registries. The Secretary also may use global outcome measures and population-based measures for this category.
- b. Resource Use:** Includes measures used in the current VBM program, with additional refinements based on public input. These refinements must identify specific clinical criteria and patient characteristics to allow patients to be classified into care episode groups and patient condition groups for resource use measurement purposes. The process also must

develop patient relationship categories and codes that distinguish the relationship with, and responsibility of a physician toward, a patient at the time of furnishing an item or service. In measuring resource use, the Secretary must use per-patient total allowed charges for all services under Part A and Part B and, if the Secretary determines appropriate, Part D, by care episode codes and by patient condition codes.

- c. Clinical Practice Improvement Activities:** Reflects professionals' efforts to improve clinical practice or care delivery in a way that is likely to result in improved outcomes. Subcategories include at least the following: expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an alternative payment model. Recognized activities will be established in collaboration with professionals, and must include consideration of small practices and professionals in rural and health professional shortage areas.
- d. Meaningful Use:** Includes current EHR Meaningful Use requirements, demonstrated by use of a certified system.

The Secretary may use inpatient hospital quality measures for the quality and resource-use measures, but the Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

The Secretary is directed to assess appropriate adjustments to quality measures, resource-use measures, and other MIPS measures, performance scores, and payment adjustments to take into account “an individual’s health status and other risk factors.”

MIPS measures will be identified and updated annually through public notice and comment rulemaking, and in conformance with very detailed stakeholder input requirements. Eligible professionals may themselves select from the qualified measures for purposes of assessment for a performance period. MIPS performance information will be included on the CMS Physician Compare website.

4. MIPS Performance Scoring and Payment Adjustments

The Secretary must establish performance standards for MIPS measures and activities annually, taking into account historical performance, improvement, and opportunity for continued improvement. Beginning in 2019, eligible professionals will receive a composite performance score of 0-100 based on their performance in each of the four performance categories (as applicable), which will be compared with a performance threshold. The performance threshold for a year generally will be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals for a prior period specified by the Secretary.

Eligible professionals will be permitted to elect to have their performance assessed as part of a “virtual” group, such as on the basis of geographic area or provider specialty, if certain requirements are met.

The bill sets forth certain parameters for weighting the MIPS factors for performance scoring purposes, and for taking into account both improvement and achievement.

Eligible professionals will receive either a negative adjustment, no adjustment, or a positive adjustment based on how their composite performance scores compare with the threshold. Payment adjustments will follow a linear distribution.

- **Negative Adjustments:** The maximum negative adjustment will be as follows: 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and subsequent years. The maximum negative adjustment will apply to eligible professionals whose composite performance score falls between 0 and one-fourth of the performance threshold, and smaller negative adjustments will apply to composite performance scores closer to the threshold. Such negative adjustments will fund positive payment adjustments for professionals with composite performance scores *above* the threshold.
- **Zero adjustments:** Composite performance scores *at* the threshold will receive no MIPS payment adjustment.
- **Positive adjustments:** Eligible professionals whose composite performance scores are above the threshold will receive a positive payment adjustment, with higher performance scores receiving proportionally larger incentive payments. The magnitude of positive payment adjustments will vary, and will maintain budget neutrality considering the amount of negative payment adjustments (except in certain limited circumstances), with a cap of three times the annual cap for negative payment adjustments.
- **Additional Incentive Payment Adjustment:** An additional adjustment will be available for exceptional performance on a linear distribution basis, with better performers receiving larger incentive payments. Aggregate additional incentive payments will equal \$500 million annually for each of 2019 through 2024.

C. Promoting Alternative Payment Models

MACRA includes payment incentives to encourage providers to participate in alternative payment models that focus on coordinating care, improving quality, and reducing costs.

1. *Criteria for Physician-Focused APMs*

In general, this program applies to payments made through arrangements meeting specified quality measures and using certified EHR technology, and that either bear more than nominal financial risk if actual aggregate

expenditures exceed expected aggregate expenditures (such as an accountable care organization), or is a Medicaid medical home.

Not later than November 1, 2016, the Secretary must, through notice and comment rulemaking, establish specific criteria for physician-focused payment models, including models for specialist physicians. Stakeholders may submit proposals for physician-focused payment models that they believe meet the specified criteria. Such proposals will be reviewed by a new “Physician-Focused Payment Model Technical Advisory Committee,” which will advise the Secretary on whether the suggested models meet the criteria. The Secretary ultimately will respond publicly to the requests.

2. Standards for Qualifying APM

MACRA provides two tracks for APM participation, with one track requiring that a higher portion of Medicare revenue be attributable to an APM, and a second track that recognizes APM revenue from both Medicare and other payers (to enable professionals to qualify for bonuses even if APM options in their area are limited). Subject to other detailed criteria, in order to be considered a qualifying APM participant:

- In 2019 and 2020, at least 25 percent of the Part B payments to the professional during the most recent period for which data are available must be furnished through an eligible alternative payment entity.
- In 2021 and 2022, either (1) at least 50 percent of Part B payments to the professional are furnished through an eligible alternative payment entity, or (2) at least 50 percent of all payments made are the sum of (a) at least 25 percent of Medicare Part B payments furnished through an eligible alternative payment entity, and (b) payments made by other payers under arrangements in which quality measures apply, EHR technology is used, and that either bear more than nominal financial risk or meet the standards of a Medicaid medical home.
- In 2023 and each subsequent year, (1) at least 75 percent of Part B payments to the professional are furnished through an eligible alternative payment entity, or (2) at least 75 percent of all payments made are the sum of (a) at least 25 percent of Medicare Part B payments furnished through an eligible alternative payment entity, and (b) payments made by other payers under arrangements in which quality measures apply, EHR technology is used, and that either bear more than nominal financial risk or meet the standards of a Medicaid medical home.

MACRA also establishes thresholds for providers considered to be a partial qualifying APM participant. The Secretary has the discretion to base the determination of whether an eligible professional is a qualifying APM participant by using counts of patients in lieu of payments.

3. APM Payment Provisions

Eligible professionals participating in qualifying APM will receive an APM bonus each year from 2019 through 2024 equal to 5 percent of the estimated aggregate payment amounts for covered Part B professional services for the preceding year if certain conditions are met. Payment will be made in a lump sum, on an annual basis.⁴

In addition, as previously noted, beginning in 2026, a professional will receive a larger conversion factor update (0.75 percent versus 0.25 percent) if the professional participates in a qualifying APM. Professionals who are qualified APM participants or partial qualifying APM participants also are excluded from MIPS payment adjustments.

D. Other Provisions

MACRA includes a number of other policies intended to facilitate or complement the revised physician payment system. For instance, MACRA:

- Directs the Secretary to establish a **plan for the development of quality measures**, in consultation with the public. Priority must be given to: outcome measures, including patient reported outcome and functional status measures; patient experience measures; care coordination measures; and measures of appropriate use of services, including measures of overuse. MACRA provides up to \$15 million annually for FYs 2015 through 2019 for this purpose.
- Directs the Secretary to make payment (as the Secretary determines to be appropriate) for **chronic care management services** furnished on or after January 1, 2015; such payment may not be duplicative of other Medicare payment.
- Expands the **publicly available information about physician services** furnished to Medicare beneficiaries, including information on volume, charges and payments, and allows qualified entities to sell Medicare data analyses to providers and clinical data registries to assist in quality improvement activities, under certain conditions.
- Declares it a national objective to achieve widespread exchange of health information through **interoperable certified EHR technology** nationwide by December 31, 2018.

⁴ The OIG is directed to study the extent to which the APM payments are vulnerable to fraudulent activity and make recommendations as appropriate.

- Provides that federal health standards under Medicare, Medicaid, or the Affordable Care Act “shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any **medical malpractice or medical product liability action or claim.**”

II. Medicare and Other Health Extenders

A. Medicare Extenders

1. Extension of Medicare Part B Therapy Cap Exceptions Process

MACRA maintains the status quo for outpatient therapy services by extending the exceptions process for outpatient therapy caps through December 31, 2017. The Medicare program has annual limitations (or caps) on the amount of expenses a patient can accrue for outpatient therapy services in a given year. Currently, exceptions to the therapy caps are allowed for reasonable and necessary therapy services. MACRA extends the therapy cap and exceptions process to therapy services furnished in a hospital outpatient department through January 1, 2018 (rather than permitting them to expire March 31, 2015).

Additionally, MACRA replaces the manual medical review process for services rendered by therapy providers with a new medical review process using such factors as the Secretary determines to be appropriate. MACRA specifies that such factors may include:

- Whether the therapy provider has a high claims denial percentage for therapy services or is less compliant with applicable requirements.
- Whether the therapy provider has a pattern of billing for therapy services that is aberrant or questionable compared with peers', or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day.
- Whether the therapy provider is newly enrolled or has not previously furnished therapy under Medicare.
- The types of medical conditions treated by the services.
- Whether the therapy provider is part of a group.

The new factors apply to exception requests for which the Secretary has not conducted a medical review by a date within 90 days of enactment.

2. Addition Medicare Policy Extensions

MACRA extends for almost two years, until January 1, 2018, certain other Medicare policies, including: the floor used in the Medicare physician work geographic adjustment (set to expire April 1, 2015); certain add-on payments

for ambulance transports that originate in rural areas (set to expire April 1, 2015); and a 3 percent add-on for payments associated with home health services furnished in a rural area (set to expire January 1, 2016).

MACRA extends until October 1, 2017 certain Medicare policies currently set to expire April 1, 2015. These policies include increased inpatient hospital payments for higher costs associated with low-volume hospitals, and an extension of special payments for the Medicare-dependent hospital program (rural hospitals with less than 100 beds that serve a high percentage of Medicare beneficiaries that are currently reimbursed based on a blending of prospective payment system rates and costs). MACRA also extends the authority of Medicare Advantage special needs plans to limit enrollment to specific sets of individuals through December 31, 2018, which is currently set to expire January 1, 2017.

MACRA additionally fully funds the National Quality Forum's review, endorsement and, maintenance of quality and resource-use measures. Prior law provided \$15 million in funding through the first six months of FY 2015; the MACRA extension allots \$30 million for each fiscal year through 2017.

MACRA also extends outreach and assistance funding through FY 2017 for: State Health Insurance Programs; Area Agencies on Aging; Aging and Disability Resource Centers; and contracts with the National Center for Benefits and Outreach Enrollment.

3. Transition and Extension of Medicare Reasonable Cost Contracts

MACRA provides a one-year transition period to allow organizations that offer reasonable cost reimbursement contracts that no longer meet statutory requirements to continue to operate under Medicare in their specific service area in certain circumstances. The provision includes detailed rules for organizations and protections for beneficiaries with cost plans to smooth the transition to Medicare Advantage plans.

B. Other Health Extenders

1. Permanent Extensions of Expiring Provisions

MACRA permanently establishes certain Medicare program policies that have consistently been extended in past years and were set to expire March 31, 2015. Specifically, MACRA makes permanent the Qualifying Individual Program helping low-income Medicare beneficiaries cover the cost of Medicare Part B premiums, and the Transitional Medical Assistance Program helping low-income families maintain Medicare coverage for up to a year while transitioning from welfare to work.

2. Various Other Health Extensions

MACRA extends numerous health policies through FY 2017, including: the special diabetes programs for type 1 diabetes and for Indians; the abstinence-only education program; the personal responsibility education program;

the health workforce demonstration project for low-income individuals; the maternal, infant, and early childhood home visiting program; and funding for the extension of family-to-family health information centers.

MACRA also allocates certain special Medicaid disproportionate share hospital funding for the state of Tennessee through FY 2025. Additionally, MACRA extends funding for Community Health Centers, the National Health Service Corps fund, and Teaching Health Centers. Each of these programs was set to expire in 2015, and MACRA extends mandatory dedicated funding through FY 2017.

3. Estate Recovery

The Bipartisan Budget Act of 2013 overturned a circuit court opinion that dealt with estate recovery by Medicaid. The Bipartisan Budget Act provided that states may recover medical expenses from any portion of a Medicaid beneficiary settlement, potentially allowing a state to appropriate money originally set aside for a beneficiary's future care or living expenses. MACRA delays the implementation of this statute until October 1, 2017.

III. Children's Health Insurance Program (CHIP)

CHIP is a program that covers approximately 8 million children and pregnant women whose income falls slightly above Medicaid eligibility levels. Although CHIP is currently authorized through 2019, funding would lapse after FY 2015. MACRA provides a two-year extension of CHIP, funding the program through FY 2017. Additionally, MACRA extends and funds the express lane eligibility program, the outreach and enrollment program, the pediatric quality measures program, and the childhood obesity demonstration project. MACRA requires the HHS Office of the Inspector General (OIG) to study the integrity of CHIP, relating to the express lane eligibility program.

IV. Offsets

MACRA includes several provisions that partially offset the cost of the new Medicare physician payment framework, and extension of CHIP and other expiring provisions. These provisions both increase cost sharing for certain Medicare enrollees and reduce payments to hospitals and post-acute care providers.

A. Medicare Beneficiary Cost-Sharing

MACRA bars Medigap policies from offering "first-dollar" coverage for new beneficiaries beginning in 2020. Specifically, Medicare supplemental policies that provide coverage of the Part B deductible may not be sold or issued to a newly eligible Medicare beneficiary on or after January 1, 2020. The Congressional Budget Office (CBO) estimates that this provision will save \$0.4 billion from 2023 to 2025.⁵

⁵ The CBO cost estimate is available at <http://www.cbo.gov/publication/50053>.

MACRA also increases income-related premiums for Medicare Part B beginning in 2018 for certain higher-income beneficiaries. Specifically, MACRA increases the percentage paid by Medicare beneficiaries with modified adjusted gross income (MAGI) between \$133,501 and \$160,000 (\$267,001-\$320,000 for a couple) from 50 percent to 65 percent. Beneficiaries that earn \$160,001 and above (\$320,001 and above for a couple) will pay 80 percent (currently the threshold for the 80 percent level is income of more than \$200,000). These thresholds also apply to income-related Part D premium adjustments. In addition, MACRA adjusts the inflation update to the thresholds. The CBO estimates that these changes will reduce Medicare spending by \$34.3 billion from 2018 through 2025 – the single largest offset in the law.

B. Provider Offsets

1. Post-Acute Care Medicare Market Basket Reductions

MACRA sets the annual prospective payment system (PPS) update for FY 2018 at 1 percent for the following types of post-acute care providers: skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospices, and long-term care hospitals. The CBO estimates that this provision will reduce Medicare spending by a total of \$15.4 billion from 2018 through 2025.

2. Restructured Medicaid DSH Hospital Reductions

MACRA modifies planned reductions in Medicaid disproportionate share hospital (DSH) payments by delaying FY 2017 cuts until FY 2018, restructuring the overall level of reductions, and extending cuts through FY 2025. This provision has the effect of boosting payments during the period of 2017 through 2020 but decreasing payments in later years, resulting in a \$4.1 billion reduction in spending over the 2017 through 2025 budget window.

3. Levy on Medicare Providers for Nonpayment of Taxes

The Department of the Treasury currently may impose a levy of up to 30 percent against payment due to a Medicare provider or supplier with tax delinquencies. MACRA allows the Department of the Treasury to withhold up to 100 percent of Medicare payments to satisfy a delinquent tax debt. This provision is expected to save \$0.6 billion from 2015 through 2025.

4. Adjustments to Inpatient Hospital Payment Rates

MACRA replaces a scheduled one-time, 3.2 percent additional adjustment to acute inpatient PPS (IPPS) rates in FY 2018 with a 0.5 percent per year additional adjustment over six years beginning in FY 2018. This provision is estimated to save \$15.1 billion over the 2018 through 2025 period.

V. Other Medicare Policy Provisions

A. Protecting the Integrity of Medicare Act of 2015 (PIMA)

1. *Prohibition on Inclusion of Social Security Account Numbers on Medicare Cards*

MACRA amends the Social Security Act (42 U.S.C. § 405(c)(2)(C)) to establish cost-effective procedures to ensure that Medicare beneficiaries under Medicare Part A or Medicare Part B do not have their Social Security account number displayed, coded or embedded on their Medicare benefits card (and that no other identifier on the card is identifiable as a Social Security account number).

To implement this change, MACRA directs the Secretary to establish a cost-effective process that involves the least amount of disruption to Medicare beneficiaries and health care providers, such as a process that provides Medicare beneficiaries with access to assistance through a toll-free telephone number and provides outreach to providers.

MACRA specifies an effective date for the implementation of Medicare cards without inclusion of Social Security account numbers to be no later than four years after the date of MACRA's enactment.

2. *Preventing Wrongful Medicare Payments for Items and Services Furnished to Incarcerated Individuals, Individuals not Lawfully Present, and Deceased Individuals*

MACRA requires the Secretary to establish and maintain procedures for using claim processing edits, updating eligibility information to improve provider accessibility, and conducting recoupment activities through recovery audit contractors in order to ensure that payment is not made for items and services furnished to an individual who is incarcerated, who is not lawfully present in the United States and is not eligible for Medicare coverage, and any individual who is deceased.⁶

3. *Consideration of Measures Regarding Medicare Beneficiary Smart Cards*

MACRA authorizes the Secretary to consider the use of electronic Medicare beneficiary and provider cards using smart card technology (including an embedded and secure integrated circuit chip) to the extent such changes are technologically viable and cost effective.

⁶ MACRA specifies that no later than 18 months after its enactment, the OIG must submit a report on the status of such procedures.

4. Modifying Medicare DME Face-to-Face Encounter Documentation Requirement

MACRA revises the requirement that a *physician* document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with a patient during the 6-month period before an order is written for the DME. Specifically, MACRA now permits *not only the physician* but also a nurse practitioner, physician assistant or clinical nurse specialist to document such face-to-face encounter (as allowed by state law).

5. Reducing Improper Medicare Payments

MACRA amends the Social Security Act (42 U.S.C. § 1395kk-1) to require each Medicare Administrative Contractor (MAC) to establish and have in place an “improper payment outreach and education program” under which the MAC, through outreach, education, training, and technological assistance, will offer providers and suppliers information such as:

- A list of providers’ or suppliers’ most frequent and expensive payment errors over the last quarter.
- Specific instructions regarding how to correct or avoid such errors in the future.
- A notice of new topics that have been approved for audits conducted by recovery audit contractors.
- Specific instructions to prevent future issues related to such new audits and other information as deemed necessary by HHS.

Under the new program, a MAC must give priority to activities that will reduce improper payments associated with:

- Items and services that have the highest rate of improper payment.
- Items and service that have the greatest total dollar amount of improper payments.
- Errors due to clear misapplication or misinterpretation of Medicare policies.
- Errors clearly due to common and inadvertent clerical or administrative errors.
- Errors due to other types of errors that HHS determines could be prevented through activities under the program.

MACRA requires the Secretary to provide each MAC a complete list of the types of improper payments identified by recovery audit contractors, including:

- Providers of services and suppliers that have the highest rate of improper payments.

- Providers of services and suppliers that have the greatest total dollar amount of improper payments.
- Items and services furnished in the region with the highest rates of improper payments.
- Items and services furnished in the region that are responsible for the greatest total dollar amount of improper payments.
- Other information the Secretary determines would assist the contractor in carrying out the program.

MACRA also authorizes the Secretary to retain a portion of the amounts obtained by recovery audit contractors to fund CMS initiatives to reduce the Medicare payment error rate.⁷ MACRA makes clear that the improper payment and outreach program will not reduce payments to recovery audit contractors.

6. Improving Senior Medicare Patrol and Fraud Reporting Rewards

MACRA directs the Secretary to develop a plan to revise the incentive program under section 203(b) of the HIPAA Act (42 U.S.C. § 1395b-5(b)) to encourage greater participation by individuals to report fraud and abuse in the Medicare program. Specifically, MACRA notes that such plan should include recommendations for:

- Ways to enhance rewards for individuals reporting under the incentive program, including rewards based on information that leads to an administrative action.
- Extending the incentive program to the Medicaid program.

MACRA also directs the plan to include recommendations for the use of Senior Medicare Patrols to conduct a public awareness and educational campaign to encourage participation in the incentive program. MACRA specifies that the plan to revise the incentive program must be submitted to Congress within 180 days of MACRA's enactment.

7. Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims

MACRA requires for plan year 2016 and beyond that claims for a covered Part D drug for a Part D eligible individual enrolled in a prescription drug plan under Medicare Part D or a Medicare Advantage prescription drug plan under Medicare Part C include a prescriber National Provider Identifier (NPI).

MACRA directs the Secretary to establish procedures to determine the validity of the prescriber NPI. MACRA also directs the Secretary to establish procedures to ensure that when a claim for a covered Part D drug is denied

⁷ MACRA notes that the amounts retained will not exceed 15 percent of the amounts recovered, and such amounts may not be used for technological-related infrastructure, capital investments, or information systems (except for uses that support claims processing and system functionality for detecting fraud).

because the claim does not meet prescriber NPI requirements, the individual is properly informed at the point of service of the reason for the denial.⁸

8. Option to Receive Medicare Summary Notice Electronically

Beginning in 2016, MACRA amends the Social Security Act (42 U.S.C. § 1395b-7) to permit a Medicare beneficiary to elect to receive in electronic format a statement that lists the item or service for which payment has been made and the amount of such payment for each item or service. If an individual elects to receive such statement electronically, MACRA specifies that such statements for subsequent periods will also be provided electronically. Beginning in 2017, MACRA also directs the Secretary to provide a clear notification of the option to elect to receive statements in an electronic format.

9. Renewal of MAC Contracts

MACRA amends the contract term for MACs from five years to 10 years. The change in term applies to contracts in effect as of the date of enactment of MACRA and with respect to contracts entered into thereafter. MACRA also directs the Secretary to make available to the public the performance of each MAC regarding certain performance requirements and measurement standards, to the extent possible without compromising the process for entering into and renewing contracts.

10. Study on Pathway for Incentives to States for State Participation in Medicaid Data Match Program

MACRA directs the Secretary to study and specify incentives for states to work with the Secretary to protect federal and state share of expenditures under the Medicaid program, as well as the Medicare-Medicaid Data Match Program.

11. Guidance on Application of Common Rule to Clinical Data Registries

MACRA requires the Secretary to clarify whether the Common Rule (45 C.F.R. § 46.101 et seq.) applies to activities (e.g., quality improvement activities) involving clinical data registries.

12. Eliminating Certain Civil Money Penalties; Gainsharing Study and Report

MACRA amends the civil money penalty (CMP) law to clarify that arrangements between hospitals and physicians that reward physicians for reducing or limiting unnecessary services are not subject to CMP liability. Previously, the CMP law prohibited payments to a physician as an inducement to reduce or limit services. The law now

⁸ MACRA requires the OIG to submit a report to Congress examining the effectiveness of such procedures no later than January 1, 2018.

specifies that the prohibition applies to inducements to reduce or limit “medically necessary” services. MACRA also directs the Secretary (in consultation with the OIG) to report to Congress regarding the available options to permit gainsharing arrangements that would improve care, reduce waste, and increase efficiency, but that would – absent legislative and regulatory amendments – otherwise be subject to CMPs. MACRA specifically requires the report to address how to limit inducements to “stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care.” The report is due within one year of enactment.

13. Modification of Medicare Home Health Surety Bond Condition of Participation

MACRA modifies the surety bond requirement for Medicare-certified home health agencies, removing references to the four-year time limitation and increasing the minimum amount to \$50,000. This change gives the Secretary greater flexibility with the surety bond requirement, allowing simply a determination that the surety bond is “commensurate with the volume of payments to the home health agency.”

14. Oversight of Medicare Coverage of Manual Manipulation of the Spine to Correct Subluxation

MACRA establishes a medical review process for spinal subluxation services performed by a chiropractor, to determine whether such services are reasonable and necessary, effective for services after January 1, 2017. Specifically, MACRA directs the Secretary to focus medical review efforts on spinal subluxation services that are being furnished by a chiropractor with “aberrant” billing practices (as compared with peers), or with service denial percentages in the 85th percentile or greater (taking into account appealed denial results). For services that are part of an episode of treatment involving more than 12 services, MACRA requires the Secretary to impose a prior authorization requirement. Otherwise, MACRA authorizes the Secretary to impose pre-payment or post-payment medical reviews on spinal subluxation services.

With respect to services subject to the prior authorization requirement, MACRA authorizes the Secretary to lift the prior authorization requirement once the Secretary determines that a particular chiropractor has a low denial rate, and also authorizes the Secretary to reintroduce the prior authorization requirement if merited, based upon the chiropractor’s billing practices and/or denial rates. Chiropractors will be allowed to request prior authorization in advance of furnishing the 12th service and can obtain prior authorization for multiple services “at a single time rather than on a service-by-service basis.” Coverage determinations must be made within 14 business days from receipt of supporting documentation for the services, or the services will not be subject to the payment prohibition that would otherwise apply if prior authorization were denied.

MACRA allows the Secretary to use any contractor to implement these requirements, other than a recovery audit contractor. In preparation for these medical review requirements, MACRA directs the Secretary to work with stakeholders (including the American Chiropractic Association) and MACs to educate and train chiropractors on how to appropriately document the medical necessity of their services beginning January 1, 2016. Finally,

MACRA requires the GAO to study the effectiveness of these medical review requirements and report its findings to Congress within four years.

15. National Expansion of Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport

MACRA directs the Secretary to expand testing of a prior authorization requirement for repetitive scheduled non-emergent ambulance transportation into additional states. Depending on the outcome of that expansion, and whether it reduces spending without compromising quality of care or limiting coverage, MACRA requires the Secretary to implement a prior authorization requirement for such activities.

16. Repeal of Duplicative Medicare Secondary Payor Provision

MACRA repeals a section of the Social Security Act that requires an elaborate process to identify potential situations where a Medicare beneficiary might have group health plan coverage through an employer that is primary to Medicare under the Medicare Secondary Payor provisions. The process being eliminated involves, among other things, a data exchange between the Internal Revenue Service and the Social Security Administration, and outreach by Medicare contractors to beneficiaries' employers. Note that group health plans must continue to comply with related reporting provisions under the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

17. Plan for Expanding Data in Annual CERT Report

MACRA directs the Secretary to develop a plan to include in the HHS Comprehensive Error Rate Testing (CERT) program annual report, data on services for which the Medicare physician fee schedule amount exceeds \$250 and the error rate exceeds 20 percent. The Secretary must submit its plan to Congress by June 30, 2015.

B. Delay of Two Midnight Enforcement

MACRA extends provisions of the Protecting Access to Medicare Act of 2014 (PAMA) that limited enforcement of Medicare inpatient hospital admission and medical review criteria commonly known as the "Two Midnight" Rule. Under the Two Midnight policy – which was adopted in the final FY 2015 Medicare IPPS rule – surgical procedures, diagnostic tests and other treatments (in addition to services designated as inpatient-only) are generally considered appropriate for inpatient hospital admission under Medicare Part A when: (1) the physician expects the beneficiary to require a stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation.

PAMA barred recovery audit contractors (RACs) from conducting post-payment patient status reviews related to this policy for inpatient claims with dates of admission on October 1, 2013 through March 31, 2015, "unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care." MACRA extends this

prohibition on RAC reviews until September 30, 2015. MACRA also specifies that the Secretary may continue previously announced “probe and educate” medical review activities through September 30, 2015 as appropriate.⁹

C. DMEPOS Competitive Bidding Program Provisions

MACRA incorporates provisions from H.R. 284, the Medicare DMEPOS Competitive Bidding Improvement Act of 2015, which was approved separately by the House of Representatives March 16, 2015. As adopted, MACRA requires Medicare suppliers that bid under a DMEPOS competitive bidding program to obtain a \$50,000 – \$100,000 “bid surety bond” for each competitive bidding area (CBA). If the bidder is offered a contract for any product category in the CBA, and the supplier’s bid for the product category was at or below the median composite bid rate that was used to calculate single payment amounts, the bid bond would be forfeited if the supplier did not accept the contract. In all other cases, the bid bond would be returned to the bidder. This provision is intended to prevent suppliers from submitting – but not accepting -- “low-ball” bids that artificially drive down prices to improve the supplier’s chances of being offered a contract.

MACRA also codifies that competitive bidding contracts can only be awarded to suppliers that meet applicable state licensure requirements.

D. Payment for Global Surgical Packages

MACRA blocks a CMS policy announced in the final calendar year 2015 MPFS rule that required the transition of all 10-day and 90-day global surgical packages to 0-day global periods (the provision does not prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services).

Instead, by 2017, the Secretary is directed to periodically collect information from a representative sample of physicians regarding the number and level of services and other items furnished during the global period, using a process to be established through rulemaking. The Inspector General is required to audit a sample of this information for accuracy. Based upon on this information, values for services with a global period must be reassessed every four years beginning with 2019. With respect to global period services for which a physician is required to report information, the Secretary is authorized to delay 5 percent of payments to “incentivize” reporting. The Secretary also may discontinue the requirement for collection of information if the Secretary has adequate information from other sources (e.g., clinical data registries, surgical logs, billing systems, or electronic health records) to accurately value global surgical services.

⁹ CMS announced April 1, 2015 (prior to Senate consideration of MACRA) that it was complying with these provisions in expectation of the legislation’s eventual enactment (see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>).

Conclusion

While there is significant relief among the physician community that the SGR saga is over, the reformed physician payment framework may lead to new battles down the road. The CMS Office of the Actuary already has identified several potential challenges created by MACRA. Specifically, in an April 9, 2015, memo,¹⁰ the Chief Actuary warns that MIPS updates totaling \$500 million per year and a 5 percent annual APM bonus are scheduled to expire in 2025, which will again trigger physician payment reductions. In addition, the new statutory physician payment update amounts do not vary based on underlying economic conditions or physician cost increases, and “would be inadequate in years when levels of inflation are higher or when the cumulative effect of price updates not keeping up with physician costs becomes too large.” Because CMS estimates that physician payment rates under the new law would be lower than those scheduled under the SGR formula by 2048, CMS expects “access to Medicare-participating physicians to become a significant issue in the long term” under MACRA absent a subsequent legislative change in the method or level of update. Thus, while the inherent problems with the SGR formula are solved in the short-term, Congress may be fated to wrestle with the continued complex issues of Medicare physician reimbursement methodology in the years to come. These economic realities, coupled with the transformation for the payment methodology to a more value-based model, mean that major changes lie ahead for Medicare payments to physicians and other providers and suppliers.

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¹⁰ <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/2015HR2a.pdf>.

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