



Medicare Access and CHIP Reauthorization Act of 2015—H.R. 2

The American Medical Association and over 750 national and state-based physician and specialty organizations have gone on record in support of H.R. 2, the “Medicare Access and CHIP Reauthorization Act.” Many physicians have questions about the major provisions of the legislation, and others have been disturbed by incomplete or incorrect interpretations of the bill’s legislative language. Below are responses to frequently asked questions about the major provisions of H.R. 2 that will affect Medicare physician payments; following these FAQs are Myth-Fact clarifications to incorrect interpretations of the bill that have been widely circulated.

Frequently Asked Questions about H.R. 2

What are some of the key features of H.R. 2?

Many features of this bill represent improvements over current law. Some of the most important include the following:

- The sustainable growth rate (SGR) is permanently repealed, effective immediately.
- Positive payment updates of 0.5 percent are provided for four and a half years, through 2019.
- Physicians in alternative payment models (APMs) receive a 5 percent bonus from 2019 to 2024.
- In 2026 and beyond, physicians in APMs qualify for a 0.75 percent update; all others will receive a 0.25 percent annual update.
- The fee-for-service payment model is retained, and physician participation in APMs is entirely voluntary.
- Technical support is provided for smaller practices, funded at \$20 million per year from 2016 to 2020, to help them participate in APMs or the new fee-for-service incentive program.
- Funding is provided for quality measure development, at \$15 million per year from 2015 to 2019. Physicians retain their preeminent role in developing quality standards.
- Current quality incentive and payment programs are consolidated and streamlined, and the aggregate level of financial risk to practices from penalties has been mitigated in comparison to current law.

Are there provisions that the AMA opposes?

This is not the bill we would have written ourselves. There are still some things about the quality programs, for example, that we will continue working to improve. Nothing in this bill prevents us from advocating for future legislation. In fact, because the SGR and its accumulated debt are eliminated, future modifications will not face the same budgetary obstacles.

How does the legislation support transitions to APMs?

The bill provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians participating in patient-centered medical homes, widely recognized to lower costs of care, would not be required to assume downside financial risk. Other models would require some degree of downside risk in addition to the opportunities for increased revenues that many APMs provide if the physician practice generates savings. To encourage physicians to assume this risk, and to provide a financial cushion, the legislation provides 5 percent bonus payments from 2019 to 2024 for those who join new models. This provides a transition period to support successful implementation of new models. Another advantage is that physicians would only be subject to the quality reporting requirements for their APM; they would be exempt from the new Merit-based Incentive Payment System (MIPS) quality program described below. The bill also supports the use of telemedicine in new models of care and creates an advisory panel to consider physicians' proposals for new models.

What is the Merit-based Incentive Payment System or MIPS?

Beginning in 2019, H.R. 2 provides for bonuses ranging from 4 to 9 percent for physicians who score well in the MIPS, a new pay-for-performance program under the current Medicare fee-for-service payment system. The current matrix of penalties under the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM), would end at the close of 2018. In 2019, the MIPS program would become the only Medicare quality reporting program. Performance under the MIPS would be based upon four categories: quality, resource use, meaningful use, and clinical practice improvement activities. These would build and improve upon the current quality measures and concepts in PQRS, MU, and VBM. Physicians are specifically encouraged to report quality measures through certified EHR Technology or qualified clinical data registries. Participation in a qualified clinical data registry would also count as a clinical practice improvement activity.

In many respects, the MIPS program would be more attainable for physicians than current quality programs. The MIPS program presents the first real opportunity for high-performing physicians to earn substantial bonuses, and for all physicians to avoid penalties if they meet prospectively-established quality thresholds. Several new aspects of the MIPS program support physicians scoring better, and receiving more credit for their efforts, than under current programs.

Would the MIPS do a better job of rewarding physicians for high quality performance than current programs?

Performance scoring under the MIPS program has several advantages over current quality programs:

- The MIPS does not employ the VBM's "tournament model" which requires both winners and losers, thereby potentially penalizing even-high performing physicians since someone has to be a loser. In the MIPS, if all physicians perform at or above the performance threshold, no one would get a penalty.
- Performance assessment under the MIPS program would be according to a "sliding scale"—versus the current "all or nothing" approaches used in PQRS and MU. Credit would be provided to those who partially meet the performance metrics.
- The bill has guidelines for the weighting of the four performance categories, yet specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.

- At the start of each performance period, physicians would know the threshold score for successful performance, and they would receive timely (such as quarterly) feedback on their individual performance.
- Physicians could receive substantial credit for clinical practice improvement activities and for improving (and achieving) quality of care.
- Physicians with a low level of Medicare claims, and those who are in APMs, would be exempt from the MIPS requirements and payment adjustments.

The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing high quality of care. For exceeding the performance threshold, physicians could earn bonuses of up to: 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and beyond. Additional funding is provided for exceptional performance, up to \$500 million per year, from 2019 through 2024. So even if all physicians score above the threshold, some will still receive incentive payments. Unlike current law, the MIPS penalties provide greater certainty, and have a maximum range in future years.

Is H.R. 2 consistent with AMA policy on pay-for-performance?

The AMA has worked throughout the negotiations on this legislation to bring it more closely in line with our extensive policy on pay-for-performance. As a result of AMA advocacy, the pending legislation more closely aligns with our P4P policy than previous legislative proposals and is an improvement over current law.

Does the bill include any liability protection for physicians?

Yes, the bill contains a provision similar to the Standard of Care Protection Act. This will protect physicians by preventing quality program standards and measures (such as PQRS/MIPS) from being used as a standard or duty of care in medical liability cases.

How does the bill support chronic care management services?

H.R. 2 would require Medicare to reimburse, under at least one payment code, monthly care management services for individuals with chronic care needs. Payment would go to one professional practicing in a patient-centered medical home or comparable specialty practice certified by a recognized organization. No linkage is required to an annual wellness visit or initial preventive physician examination.

What does the bill say about the release of physician claims data?

Starting in 2014, CMS began to publicly release physician-identified Medicare claims data on an annual basis. The bill would continue to allow the public release of these data. The bill retains provisions that the AMA has supported that allow the sale of non-public data and analyses by Qualified Entities, with certain safeguards.

Does the bill address private contracting?

Physicians who choose to opt out of Medicare to engage in private contracting could elect to automatically renew their status; they would no longer be required to renew their opt-out status every two years. The bill also requires regular reporting about physicians who choose to opt out of Medicare.

Does H.R. 2 make any positive changes to the EHR Meaningful Use program?

The bill sets a target of achieving interoperability of electronic health records by the end of 2018. It also prohibits the deliberate blocking of information sharing.

Will Medicare's plans to eliminate the 10-day and 90-day global surgical service bundles be addressed?

The decision by the Centers for Medicare & Medicaid Services (CMS) to eliminate bundled payments for 10-day and 90-day global surgical services has been reversed; instead, CMS will collect data on these services beginning in 2017 to determine the accuracy of payment rates. These data will be collected from a sample of physicians, rather than from all who bill global surgical services. To encourage participation, a 5 percent payment withhold may be applied until the required data are submitted.

Myths and Facts about H.R. 2

Myth: H.R. 2 mandates physician participation in Maintenance of Certification (MOC).

False. Nothing in H.R. 2 mandates maintenance of certification, nor does it penalize physicians for not participating in MOC.

Myth: H.R. 2 requires MIPS quality standards to be based only on input from certification boards, such as the American Board of Internal Medicine (ABIM) or the American Board of Medical Specialties (ABMS).

False. Professional organizations defined by certification boards are only one of many stakeholders—including other physicians and physician groups—that can provide input on quality measures under the MIPS program. Under H.R. 2, the existing PQRS, MU, and VBM programs are streamlined into the MIPS program. Many of the MIPS quality measures will be based upon existing measures that are still considered valid and are currently used for PQRS, MU, VBM, and qualified clinical data registries. The bill would require the Secretary of Health and Human Services (HHS) to 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.”

Furthermore, H.R. 2 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 other categories to choose from, and the Secretary can add more categories, in consultation with “stakeholders.”

Myth: H.R. 2 would eliminate fee-for-service completely.

False. Under H.R. 2, fee-for-service remains the basic, fundamental payment system for Medicare Part B services under the Physician Fee Schedule. H.R. 2 includes incentives and support for physicians to participate in new payment and delivery models, including \$20 million per year (from 2016-2020) in technical assistance funds for small practices to transition to new payment models or participate in the MIPS. But participation in these models is completely optional.

Myth: H.R. 2 sets a new requirement that the quality of physicians' care must be compared with the quality of care by non-physicians.

False. PQRS currently does not differentiate in its assessment of physicians and non-physicians, although all eligible professionals (EPs) are allowed to select their own quality measures. The same will be true for the MIPS program. The MIPS requirements will apply to a wide array of non-physicians—dentists, podiatrists, optometrists, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists—who are not currently subject to MU and VBM requirements. Both physician and non-physician EPs will be assessed against the same MIPS “performance threshold.”

Myth: Section 507 of H.R. 2 allows the Secretary of Health and Human Services 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 H.R. 2 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: H.R. 2 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.

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