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# Sustainable Growth Rate Reform Is Here: Should We Be Happy?

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## Introduction

On April 16, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This bipartisan piece of legislation, which overwhelmingly passed in both the House and Senate, permanently repeals the Medicare Sustainable Growth Rate (SGR) formula for physician payment and at least temporarily stabilizes Medicare payments for physician services. Given that the existing SGR formula had required 17 prior acts of Congress to avert cuts in payments to physicians and mandated a cut of 21.2% in Medicare payments this year without Congressional action, the passage of MACRA can certainly be seen as a positive step in developing a new and more stable payment system [1]. Specifically, the law outlines consistent increases in Medicare payments ("positive updates") beginning on July 1, 2015, through the end of 2019 and again in 2026 and beyond, providing a welcome period of stability for physicians. However, some potential problems are lurking in the new law. First, significant questions exist about whether the increased payments mandated by MACRA will be enough to meet the expected costs of running a medical practice. Additionally, the law proposes major changes in health care delivery models and/or extensive reporting requirements to maintain future increases in payment. In a system that has been dominated by an unsustainable fee-for-service payment model, the move toward rewarding value over volume is meaningful and fundamental change, but the unknowns associated with the requirements outlined in MACRA may also pose significant risks for physicians and further the drive away from private practices toward hospital or health system employment.

Several key components of MACRA will have an immediate impact on physicians. First, it ends the current SGR system and averts pending cuts in payment. In its place, MACRA provides updates of 0.5% per year from 2016 through 2019 while maintaining the current payment system through 2018. As of 2019, things change. Payments to physicians will then be adjusted depending on their participation in approved alternative payment models or in a new composite reporting system, the Merit-Based Incentive Payment System (MIPS). MIPS essentially will replace the existing Medicare requirements associated with the Physician Quality Reporting System, the meaningful use of electronic health records (EHRs), and the value-based modifier. Under MIPS, practitioners will be graded on a composite 0-100 scale that assigns points based on quality, resource use, meaningful use of EHRs, and practice improvement activities [2,3]. Practitioners who score highly on the MIPS will be rewarded with positive updates, whereas those who score poorly will be penalized with negative updates (ie, reductions in payment schedules). Although money is dedicated for further rewards for particularly high performers under MIPS for 2020-2025, this is really a comparative ranking system, and the negative updates applied to some providers will be used to pay for the positive updates given to others [2]. As of 2026, the rules change again, and physicians in the alternative payment model track will receive updates of 0.75%, whereas those not participating substantially in these models will receive 0.25% updates per year. A full summary of MACRA provisions is provided in Table 1.

Under MACRA, alternative payment models offer both distinct advantages and challenges. Physicians who receive a substantial amount of their Medicare reimbursement from approved alternative payment models by 2019 will be eligible for a 5% bonus payment from 2019-2025 with updates as previously described after 2025. Exactly which models are eligible for inclusion is not well specified, nor is the level of participation required. Eligible models are those currently being studied by the Center for Medicare and Medicaid Innovation, which was established by the Affordable Care Act [1]. These models are largely still under development, and thus far results have been mixed in terms of outcomes and success. By definition, participation in all of these models involves some degree of

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**Table 1**
Summary of the Medicare Access and CHIP Reauthorization Act of 2015

**Title I: SGR Repeal and Medicare Provider Payment Modernization**

- Repeals and replaces the SGR permanently, avoiding the 21.2% Medicare physician payment cut scheduled to take effective on April 1, 2015
- Increases physician pay by 0.5% per year from July 2015 through 2019 and 0% per year from 2020 through 2025; for 2026 and beyond, the update will be 0.75% for eligible alternative payment model participants and 0.25 % for all others
- Incentivizes value-based payment in the existing fee-for-service system, called the Merit-Based Incentive Payment System
  - Consolidates 3 existing quality programs (the Physician Quality Reporting System, the Value-Based Modifier, and Meaningful use of Electronic Health Records) into 1 pay-for-performance program
    - Incentivizes improved care coordination for persons with chronic care needs
    - Introduces clinical care guidelines developed by physicians to reduce inappropriate care and spending
- Incentivizes use of alternative payment models
  - Providers obtain a 5% bonus if they receive a significant amount of their revenue from alternative payment models such as accountable care organizations or patient-centered medical homes
  - Separate incentive for private pay alternative payment models
- Increases use of Medicare data
  - CMS shall post quality and utilization data on the Physician Compare Web site
  - Qualified clinical data registries can purchase claims data to improve quality and patient safety

**Title II: Medicare and Other Health Extenders**

Medicare Extenders (Subtitle A)

- Postacute Care
  - Therapy caps: extends the therapy cap exceptions process until January 1, 2018, and reforms the medical manual review process (Section 202)
- Beneficiaries
  - Extends specialized Medicare Advantage plans for special needs individuals through December 31, 2018 (Section 206)
  - Extends funding of low-income Medicare beneficiary programs, including Aging and Disability Centers, Area Agencies on Aging, National Center for Benefits Outreach and Enrollment, and State Health Insurance Programs (Section 208)
  - Extends rules and beneficiary protections for cost plans transitioning to Medicare Advantage (Section 209)
- Other Providers
  - Extends Geographic Practice Cost Index for physicians where their labor cost is lower than the national average until January 1, 2018 (Section 201)
  - Extends add-on payments for ground ambulance services, including those in super-rural areas, until January 1, 2018 (Section 203)
  - Extends add-on payments for certain low-volume hospitals until October 1, 2017 (Section 204)
  - Extends the Medicare-dependent hospital program until October 1, 2017 (Section 205)
  - Extends funding for quality measure review and selection for the National Quality Forum and the Secretary through fiscal years 2016 and 2017 (Section 207)
  - Extends 3% payment add-on for rural home health services through January 1, 2018 (Section 210)

Other Extenders (Subtitle B)

- Beneficiaries
  - Permanently extends the Medicare Qualifying Individual program, which provides premium assistance to low-income seniors (Section 211)
  - Permanently extends the Transitional Medical Assistance program, which provides coverage assistance to Medicaid beneficiaries transitioning from welfare to work (Section 212)
  - Extends the health workforce education and training demonstration project for low-income individuals through fiscal year 2017 (Section 217)
  - Delays the provision from the Bipartisan Budget Act of 2013 allowing states to recover medical expense claims from Medicaid beneficiary settlements until October 1, 2017 (Section 220)
- Programs
  - Extends funding of Family-to-Family Health Information Centers through fiscal year 2017 (Section 216)
    - This program gives grants to support family-staffed organizations to provide support to families with children with disabilities
  - Extends the Tennessee Disproportionate Share Hospital Allotment through 2025 (Section 219)

**Title III: The Children's Health Insurance Program**

- The Children's Health Insurance Program is fully funded through September 30, 2017 (a 2-year extension)

**Title IV: Offsets**

- Postacute Care Providers
  - Market basket reductions: Medicare reimbursements will increase by no more than 1.0% in fiscal year 2018 for home health providers, hospice providers, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities (Section 411)
- Beneficiaries
  - Higher Medicare Part B and D premiums beginning in 2018 for 2 brackets of seniors making more than $133,500 (Section 402)
    - Individuals earning between $133,501-$160,000 ($267,001-$320,000 for a couple): percent of premium paid increases from 50% to 65%
    - Individuals earning $\geq$$160,001 ($\geq$$320,001 for a couple): percent of premium is 80%

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Table 1 (*continued*)

- Medigap Plans
  - Limits first-dollar coverage in Medigap beginning in 2020 (Section 401)
    - Applies to certain Medigap plans by prohibiting them from covering the Part B deductible
- Hospitals and Other Providers
  - Postpones Medicaid Disproportionate Share Hospital changes until fiscal year 2018, and adds another year of cuts in 2025 (Section 412)
  - Allows the Internal Revenue Service to impose a levy of up to 100% (the current ceiling is 30%) on Medicare providers who are tax delinquent (Section 413)
  - Six-year phase-in of 3.2 percentage point adjustment in addition to their base payment beginning in fiscal year 2018 for hospitals (Section 414)

**Title V: Miscellaneous Provisions**

- Allows CMS to continue, on a prepayment basis, to use the Medicare Administrative Contractor "probe and educate" program to assess compliance with "two midnight rule" through September 30, 2015 (Section 521)
- Global surgical packages (Section 523)
  - The CMS decision to eliminate the bundled payment for surgical services that span a 10-day and 90-day period is reversed
  - CMS must collect information on the surgeons' services during these global periods beginning not later than 2017 to ensure accuracy of bundled payment amounts
  - The Secretary may delay a portion of payment for services with a 10-day and 90-day global period to incentivize reporting of information
- Additional Provisions
  - Medicare DMEPOS Competitive Bidding Improvement Act of 2015 (HR 284): Modifies the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program (Section 522)
    - This legislation modifies the existing program by requiring bids to be binding on providers who offer them
  - The Protecting Integrity in Medicare Act (HR 1021): Introduces new and strengthens existing programs to prevent Medicare fraud, waste, and abuse
    - Introduced in the House February 24, 2015, and reported in the House on March 18, 2015
    - Includes modifying durable medical equipment face-to-face requirement (Section 504), reducing improper Medicare payments (Section 505), and renewal of Medicare Administrative Contractor contracts (Section 509)

SGR = sustainable growth rate; CMS = Centers for Medicare and Medicaid Services; DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

financial risk through various types of gain-sharing structures. Although opportunities may exist to gain revenue by finding more cost-effective ways to provide care, the real possibility of losing revenue also exists. Being able to plan on future revenue given the uncertainties in these models will likely prove challenging for practitioners seeking stability. A fundamental challenge for physiatry, and for specialty medicine in general, will be how best to integrate into alternative payment structures that are largely built around primary care, such as accountable care organizations or patient-centered medical homes, or around procedural care, such as bundled payments for joint replacement or coronary surgery. Physiatrists will have to identify means of bringing value to multifactorial care systems to be successful in these models.

Although a major intent of the Affordable Care Act is to push providers and care facilities to form integrated, system-based delivery structures, essentially supplanting the long-standing model of independent physician practices [4], MACRA does contain several provisions intended to support private practices. By eliminating short-term threats of dramatic reductions in payments and consolidating existing reporting structures under MIPS, MACRA offers some relief for smaller practices. The law also requires that EHR systems be interoperable by 2018, which may lower the barriers toward achieving meaningful use for small practices and may stop the imposition of proprietary access to data by larger systems. Further, MACRA proposes some mechanisms by which small practices could share risk and potentially qualify for alternative payment models without necessarily losing autonomy to large accountable care organization structures [2]. Although potentially helpful, it is unclear if the net effect of these measures will be enough to counterbalance the rather large issues already affecting the viability of small practices, such as the extensive administrative demands of meeting reporting and EHR requirements, the financial risks associated with newer payment structures, and the potential failure of payments to really keep pace with the true costs of running a practice. Faced with all of these issues, it is not too difficult to imagine that the trend toward increasing rates of hospital and health care system employment of physicians will continue under MACRA.

One of the benefits of MACRA is the repeal of the SGR, but the long-term effects of MACRA may not be so different from what would have happened with the SGR. In April 2015, the Office of the Actuary at the Centers for Medicare and Medicaid Services released a financial analysis of the short- and long-term effects of MACRA [5]. This analysis has a number of findings that are relevant for physicians. The report estimates that the Medicare Economic Index (MEI), which reflects the changes in costs of delivering care for providers, will

increase at an expected rate of 2.3% per year. As stated in the report, "This index reflects both the price change associated with the various inputs needed to furnish physicians' services and an adjustment for productivity to capture efficiencies in the provision of these services." During the past 10 years, the average payment updates for Medicare have averaged substantially less than the MEI at 0.6% per year. With the scheduled 21% cut under the previously existing SGR law, Medicare prices would have been only about 70% of what would be necessary to meet the MEI (the actual estimated cost of delivering care) by 2025. Under MACRA, Medicare prices will still only be about 80% of what would be necessary to meet the MEI by the same year. After 2025, a number of provisions in MACRA that helped support physician payments will expire, and most physicians, including those in alternative payment models and the high performers under MIPS, will face payment reductions. A steady progression down in prices then occurs so that by 2048, Medicare prices under MACRA will actually be lower than they would have been with the prior SGR formula, even with the somewhat rosy assumption that all providers will be in alternative payment models by 2025 and thus eligible for the higher updates after that year. In summary, the report notes that although MACRA "addresses the near-term concerns of the SGR system, the issues of inadequate physician payment rates are ultimately greater." Anticipating a negative cascade of events arising from inadequate levels of payment to providers, the report concludes with the following sentence: "If not addressed by subsequent legislation, we expect that access to, and quality of, physicians' services would deteriorate over time for [Medicare] beneficiaries" [5].

So what do we have in MACRA? Some authors have stated that "we are seeing the beginning of a new chapter of efficient and effective health care payment and delivery in this country" [1]. The Energy and Commerce Committee of the House of Representatives released a statement saying, "Good Riddance! House Votes Overwhelmingly to Permanently Repeal the SGR and Strengthen Medicare," while noting that the bill, to become law, would "establish a fair and stable payment system for Medicare, protect seniors' access to their doctors, [and] begin to strengthen Medicare over the long term" [6]. However, other persons have noted that "MACRA is a disaster for doctors and patients" that "furthers the destruction of private medical practice" [7].

Perhaps the enactment of MACRA will lead to a new era of medicine in which value-based care becomes the norm and organized, interconnected systems predominate to provide better care for more people for less money. Or, perhaps, in their quest to be rid of the SGR, physicians have simply traded the devil they know for the devil they don't and headed down a road that may ultimately result in financial instability for providers, limited access to providers for Medicare beneficiaries, and lower levels of care and satisfaction all around. Unfortunately, it certainly does not seem as though the enactment of MACRA and the repeal of the SGR have really solved payment issues for the long term, and physician advocacy efforts over the Medicare payment structure are not likely to cease any time soon.

Regardless of one's perspective, several things are clear. MACRA is now the law. Providers will not face a massive reduction in Medicare payments this year, but any promised "stability" is short-lived and will ultimately be inadequate to meet the costs of running a medical practice. Over time, there will be less money in the payment system than would be needed to meet the costs of delivering care in our current system, and some providers, groups, hospitals, or others currently in the system will see a drop in revenue. To remain financially viable under the rules of MACRA, providers will need to start finding ways to improve the value of the care they provide and will have to start considering their relationships with one another, with hospitals, and with health care systems. Physiatrists will need to find ways to improve the efficiency and effectiveness of care provided within larger systems while concurrently improving patient satisfaction with that care. In particular, physiatrists will need to be able to prove and articulate their value, which will mean identifying and defining optimal pathways or mechanisms for physiatric care, advocating for our patients, and producing data that proves our worth. This is no small task, and it is one best taken on collectively by our field.

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**Highlights of Medicare Access and CHIP Reauthorization Act of 2015**

- ❖ Consolidates Medicare Quality Programs
  - ➢ Beginning in 2019, the new Merit-Based Incentive Payment System (MIPS) will become the *only* Medicare quality reporting program
    - Current penalties under the Physician Quality Reporting System, Electronic Health Records/Meaningful Use, and the Value-Based Payment Modifier will end at the close of 2018
    - New Composite Score (0-100) will be based on 4 categories—Quality (30%), Resource Use (30%), Meaningful Use (25%), Clinical Practice Improvement Activities (15%)
    - Establishes maximum bonuses and penalties—additional bonus pool of funds for top performers
    - Exemptions for alternative payment model participation and few Medicare patients
    - Group practices can report via Qualified Clinical Data Registries (QCDRs); beginning in 2016, the Medicare Access and CHIP Reauthorization Act of 2015 allows group practices to report via QCDR and encourages eligible professionals to use these registries for MIPS reporting; QCDRs will also have access to Medicare claims data to inform and assist their activities
    - Participation in clinical data registries, Maintenance of Certification (MOC) programs, and other clinical improvement activities are recognized in the new MIPS
  - ➢ Sets Priorities and Funding for Measure Development
    - From 2015 to 2019 a total of $75 million could go to physicians, physician groups, and the Physician Consortium for Performance Improvement; new evidence-based measures can be adopted without endorsement from National Quality Forum, and measures must be developed in close collaboration with physicians and other stakeholders (specialty societies develop quality measures)
  - ➢ Encourages Care Management for Individuals With Chronic Care Needs
  - ➢ Access to Information on Physicians and Expanded Data Availability
    - The Centers for Medicare and Medicaid Services (CMS) will publish quality, utilization, resource use and payment data on *Physician Compare*
  - ➢ Other Provisions
    - Requires electronic health record interoperability by 2018
    - Systems and devices can exchange data, interpret that shared data, and be understood by the user
    - Boosts physician fees in rural areas of the country through 2017
    - Preserves the current 10-day and 90-day global periods for more than 4000 surgical service codes that CMS had planned to unbundle
    - Allows CMS to use the "probe and educate" program to access compliance
    - Physicians who opt out of Medicare to privately contract no longer need to renew their opt-out status every 2 years
- ❖ Medicare Access and CHIP Reauthorization Act of 2015 Implementation Milestones
  - ➢ 2016
    - Issue proposed and final regulations for alternative payment model and MIPS
    - Availability of technical assistant funds for practices
  - ➢ 2017
    - Collection of global surgery code data
  - ➢ 2018
    - Electronic health record interoperability
  - ➢ 2019
    - MIPS and alternative payment model bonuses and penalties imposed
- ❖ Total Costs
  - ➢ $210 billion
    - $70 billion offset by a variety of provider cuts and increased beneficiary cost-sharing
    - $140 billion not offset

## Disclosure

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