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President Signs Bill to Repeal SGR, Beckons in New Era of Physician Medicare Payment

The Medicare Access and CHIP Reauthorization Act of 2015 replaced the Sustainable Growth Rate formula with statutorily prescribed physician payment updates and incentives that will accelerate progress toward physician-hospital integration. The legislation also includes provisions affecting hospitals, post-acute care providers, ambulance services, payers and other health care industry stakeholders.



BY ERIC ZIMMERMAN

On April 16, 2015, the President signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This comprehensive Medicare legislation, among other things, repealed the much-maligned Sustainable Growth Rate (SGR) formula, a statutory mechanism that caused perennial headaches for physicians and Congress alike.

New statutorily prescribed physician payment updates and incentives replace the outdated SGR formula and encourage physicians to achieve certain quality and resource utilization metrics and participate in alternative payment models (APMs).

The new pressures and expectations that this policy shift will place upon physicians will accelerate the already rapid progress toward physician-hospital integration.

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While physician payment provisions dominate the headlines, the legislation also includes dozens of other provisions of great interest and effect for hospitals, post-acute care providers, ambulance services, payers and many other health-care industry stakeholders.

The \$214 billion legislation was hailed as a rare bipartisan congressional effort. It was also strongly supported by the American Medical Association (AMA) and many other physician specialty society groups who were facing a 21 percent payment cut.

This article provides an overview of some of the more noteworthy changes included in this important legislation; it does not endeavor to summarize all aspects of the legislation, however, so interested stakeholders are encouraged to review MACRA in its entirety.

Physicians

Background

The centerpiece and *raison d'être* of the legislation is the set of provisions that eliminate the SGR formula. The SGR is a legislative mechanism established in 1997 that was intended to slow the growth of Medicare expenditures on physician services by automatically ad-

justing individual service payment amounts when aggregate payments exceeded a prescribed target.

The SGR first became a problem in 2002, when the formula mandated a 4.8 percent cut to Medicare payments. Congress allowed that cut to proceed, but that was the last time. In the years since, Congress was forced to act 17 times to prevent excessive cuts to physician services.

The SGR problem quickly ballooned into an annual, exponentially increasing congressional headache. Every prescribed cut that Congress overrode necessitated an even larger cut the following year, as the SGR formula operated to bring physician service expenditures back in line with prescribed targets.

At its peak, the SGR formula mandated cuts approaching 30 percent. Because of other brakes on physician spending, the amount of the SGR mandated cuts fell in recent years, but physicians were once again facing a 21 percent cut on April 1, 2015.

The SGR problem became more nettlesome for Congress as the cost of repealing the formula escalated and at times was projected to cost as much as \$300 billion. In 2013, a bipartisan group of representatives and senators sought to take advantage of a confluence of events that caused the estimated cost of a solution to drop to as little as \$120 billion.

This group devised a widely heralded solution to the SGR problem that would replace the SGR with statutorily prescribed updates while accelerating the amount of physician payments tied to performance measures and incentives to participate in APMs. This approach was supported by the medical community but was unable to advance because congressional leaders still

found it too difficult to agree upon other Medicare program cuts sufficient to offset the projected cost of eliminating the SGR.

As the March 31, 2015, expiration of the most recent one-year patch approached, most observers expected Congress to rally around another short-term patch. Instead, House Speaker John Boehner (R-Ohio) and Minority Leader Nancy Pelosi (D-Calif.) began a series of negotiations that resulted in MACRA.

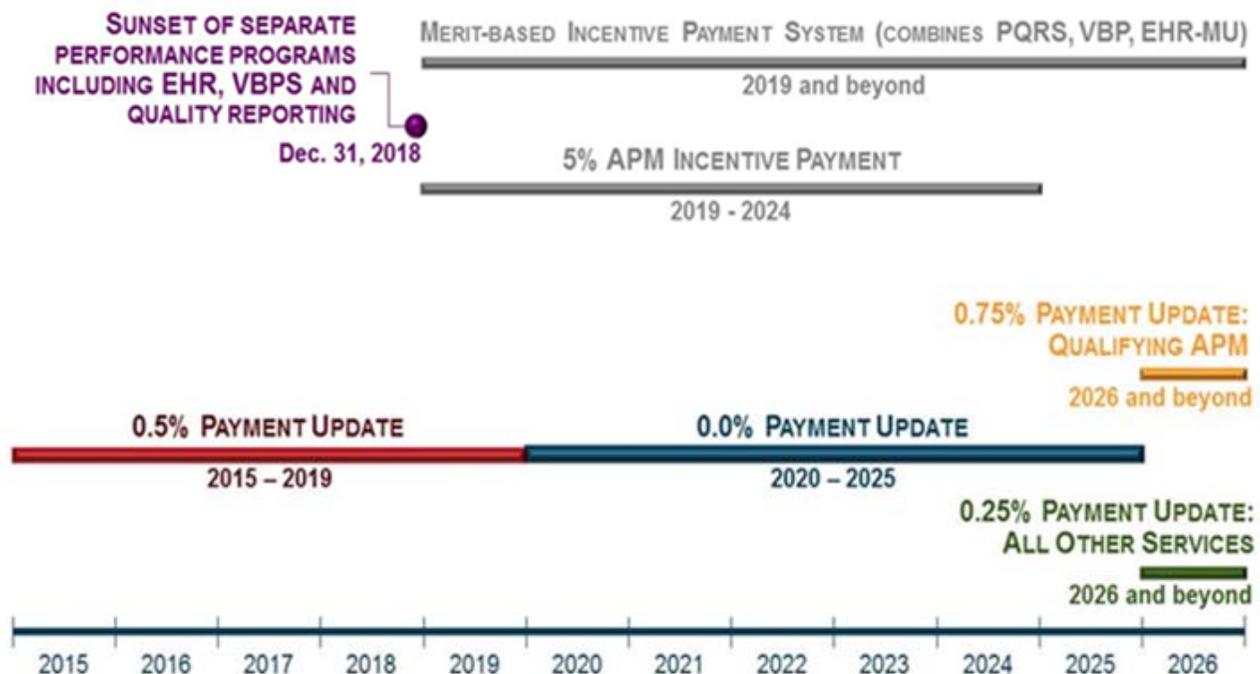
The key to their success this time was a bipartisan agreement to only *partially* offset the cost of eliminating the SGR. The two House leaders began with the 2013 compromise legislation and made only a few changes to the general framework.

Payment Updates

MACRA repeals the SGR formula and replaces it with the following statutorily prescribed updates:

- Beginning July 1, 2015, and effective January 1 of each subsequent calendar year through 2019, Medicare physician payments will be updated 0.5 percent.
- Beginning January 1, 2020, and carrying through 2025, physician payments will not be updated.
- Beginning January 1, 2026, and effective January 1 of each subsequent calendar year, physician payments will be updated 0.75 percent for physicians who adequately participate in qualified APMs, but only 0.25 percent for those who do not.

SGR Repeal and Replacement: MACRA Timeline



Physician Payment Reform

The legislation also continues and accelerates the march toward aligning physician payments with performance and incentivizing physicians to enroll in APMs. Beginning in 2019, physician payments will be substantially influenced by performance under a new Merit-based Incentive Payment System (MIPS).

The MIPS consolidates the three existing incentive programs (*i.e.*, the Physician Quality Reporting System, the Value-based Modifier program and the Electronic Health Record Meaningful Use program) with a coordinated program that seeks to avoid redundancies and inconsistencies between the existing programs.

Qualified physicians and other professionals will receive a composite performance score of 0–100 based on their performance in each of four performance categories: quality, resource utilization, meaningful use and clinical practice improvement activities.

Each eligible professional's composite score will be compared to a performance threshold determined using the performance scores of all eligible professionals. Those falling above the threshold will be eligible for a payment increase, while those falling below will receive a payment cut.

Poor performers will see payments cut by as much as 4 percent beginning in 2019, but that number will rise to 9 percent by 2022. Good performers will see a payment increase using a sliding scale based on how far above the threshold they score; the sliding scale tops out at three times the applicable negative performance cap.

The MIPS is intended to be budget neutral, so poor performers will be subsidizing good performers.

Initially, the MIPS will apply to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. The Centers for Medicare & Medicaid Services, at its discretion, can add other professional types beginning in 2021.

Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible APMs, will be excluded from the MIPS.

While MIPS is based on existing Medicare physician quality programs, additional measures may need to be developed: CMS will need to enhance the resource use methodology currently used in the VBM program, and clinical practice improvement activities—a new component of the MIPS program—will need to be developed and established.

Implementation of MIPS, an important part of a smooth transition to a new Medicare payment system for physicians, will require significant resources by CMS. It is unclear if CMS has the necessary capacity and resources to implement these changes in the timeline outlined in the legislation.

Also beginning in 2019, physicians will be incentivized to participate in an APM. Physicians who do so will receive a 5 percent bonus for the years 2019 through 2024 (beginning in 2025, physicians who participate in an APM receive a higher update than those who do not).

Two tracks will be available for professionals to qualify for the bonus. The first option will be based on receiving a significant percent of Medicare revenue

through an APM; the second will be based on receiving a significant percent of APM revenue combined from Medicare and other payers.

The MIPS program in combination with the incentives for providers to participate in APMs, has the potential to profoundly increase the administrative burden for practicing physicians. It is conceivable that many solo practitioners may not have the ability or perhaps even the desire to make the necessary changes to their practice that will be needed in order to continue seeing Medicare patients.

A trend to watch will be the impact of this legislation on solo and other small group physician practices that will come under increasing pressure to consolidate.

Geographic Practice Cost Index

Medicare payments to physicians are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the Geographic Practice Cost Indices (GPCI), that reflect how each geographic area compares to the national average.

In 2003, Congress established that for three years there would be a “floor” of 1.0 on the “work” component of the formula used to determine physician payments, which meant that physician payments would not be reduced in a geographic area just because the relative cost of physician work in that area fell below the national average. Congress has extended the work GPCI floor several times. MACRA provides yet another extension through 2017.

Global Periods

Under the Medicare Physician Fee Schedule, payment for certain surgical procedures is intended to include, in addition to the surgical procedure itself, pre- and post-operative care, including follow-up visits within a specified duration of time: 10-day global periods include follow-up visits within 10 days of surgery, while 90-day global periods include follow-up visits within 90-days of surgery.

In the rulemaking updating the Fee Schedule for CY 2015, CMS expressed concern about the pricing of some of these procedures, and whether surgeons were providing the follow-up care presumed to be included and on which the payment amount was based. After receiving comments, CMS determined to eliminate 10- and 90-day global periods beginning in CY 2017 and CY 2018, respectively.

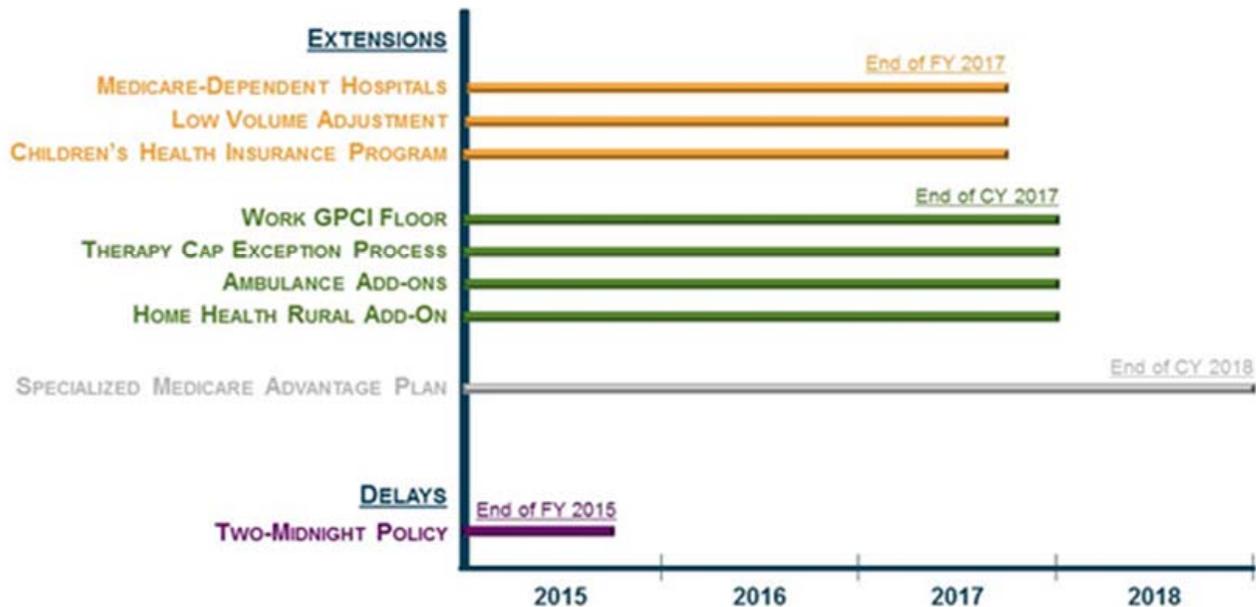
MACRA bars CMS from implementing this change but does not prohibit the agency from revaluing procedures that it believes may be mis-valued. MACRA further requires CMS to gather information necessary to determine whether surgical procedures with global periods are indeed mis-valued.

Hospitals

Low Volume

Under the Medicare Hospital Inpatient Prospective Payment System (IPPS), rural hospitals with low inpatient volumes are eligible for a percentage increase to each payment. The Affordable Care Act (ACA) substantially broadened the eligibility criteria, enabling many more hospitals to qualify for these additional payments, but time limited the expansion provision.

MACRA: Extensions and Delays



The ACA also revised the percentage increase methodology. Congress has stepped in several times since to extend that expansion, and now MACRA, continues the broader eligibility criteria for low-volume hospitals—as well as the ACA methodology for calculating such payments—through FY 2017.

Medicare-dependent Hospitals

Under the Medicare IPPS, hospitals that treat a high percentage of Medicare beneficiaries are eligible for enhanced payments, including payments on a cost basis.

Although the program has been around since 1990, Congress has periodically reauthorized it only for limited periods, and the most recent reauthorization is set to expire on March 31, 2015. MACRA reauthorizes this program for two and a half years through FY 2017.

Two Midnight Policy

In 2013, to clarify Medicare medical necessity policy around hospital inpatient admissions, CMS issued a policy specifying that an admission will qualify for Part A reimbursement when a physician certifies that a patient's treatment is expected to require an inpatient stay spanning two midnights.

In addition, CMS provided instructions to its contractors that inpatient hospital claims with lengths of stay greater than two midnights after the formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care. The policy came to be informally known as the "Two Midnight Rule."

The policy change was immediately controversial and ultimately became the subject of current litigation. In September 2013, shortly before the rule took effect, CMS announced a three-month enforcement delay during which Medicare Administrative Contractors

(MACs) were instructed to conduct a "Probe and Educate" campaign where they would review a small sample of inpatient claims lasting less than two midnights—10 for most hospitals and 25 for large hospitals—to see how well hospitals were complying with the new admissions criteria.

MACs could deny claims not in compliance with the rule during this period, but the denials would be limited to the 10/25 claims review limits. CMS MACs also would use the results of these probes to educate hospitals on how well they were doing. CMS further stated that Recovery Audit Contractors (RACs) would not be conducting any reviews of short-stay inpatient claims during the transition, and RACs would not look back at those claims at a later date.

In November 2013, CMS extended the moratorium another three months, from December 31, 2013, to March 31, 2014. On January 31, 2014, CMS announced a third delay, this time extending the prior instructions to MACs and RACs to September 30, 2014. Under this most recent delay, MACs would continue to select 10 or 25 claims per hospital with admission dates of March 31, 2014, through September 30, 2014, for review and compliance with the Two Midnight Rule.

As such, pre-payment review continued for admission dates between October 1, 2013, and September 30, 2014, and MACs would conduct outreach and education efforts based on their findings, but RACs would not conduct post-payment reviews for compliance with the Two Midnight Rule for inpatient hospital claims with admission dates between October 1, 2013, and September 30, 2014.

In April 2014, Congress enacted legislation authorizing another six-month extension of the "Probe and Educate" program, but also extending the stay on post-payment reviews for services furnished through March 31, 2015.

MACRA once again authorizes CMS to extend the “Probe and Educate” program, this time through September 30, 2015, and once again bars the agency from conducting post-payment reviews, other than in instances of suspected fraud, for discharges occurring through September 30, 2015.

Documentation and Coding Adjustments

When CMS implemented new MS-DRGs in 2008 to better classify inpatient discharges under the IPPS, the agency assumed that payments to hospitals would increase because of enhanced coding accuracy. Pursuant to administrative and legislative action, CMS made a series of adjustments to IPPS payments to recoup perceived increases in payments resulting from improved “documentation and coding.”

However, CMS committed to undo the adjustments in 2018 by making a one-time 3.2 percent payment increase. MACRA prolongs the restoration of that adjustment by implementing it in 0.5 percent increments over six years, but withholds the 0.2 percent remaining balance.

Medicaid Disproportionate Share Hospital Payment Adjustments

Under the ACA, Congress established a new methodology for allocating Medicaid Disproportionate Share (DSH) dollars among the states, and directed that the changes become effective in 2014 and last through 2021.

Subsequent legislation delayed implementation, but increased the amount of the reduction and extended the effective period. Under MACRA, implementation of the Medicaid DSH changes is further delayed to 2018. MACRA also revises the allocations and extends the cuts through 2025.

MACRA is a major piece of Medicare legislation, perhaps one of the largest to pass since the Affordable Care Act in 2010.

Post-Acute

Legislation enacted in 2000 provided a temporary 10 percent increase for home health services furnished in rural areas. That payment increase has been periodically extended, but was lowered first to 5 percent and then to 3 percent, most recently by the ACA. MACRA extends that 3 percent add-on through 2017.

MACRA also provides that payments for services furnished by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities and long-term care hospitals may not be increased by more than 1 percent in FY 2018.

Ambulances

MACRA extends several ambulance service payment add-ons through 2017, including the 3 percent increase for ground ambulance trips originating in rural areas, the 2 percent increase for ground ambulance trips origi-

nating in urban areas, special treatment for certain air ambulance services originating in rural areas, and a “super rural” add-on of 22.6 percent for ambulance services in the “lowest population density” areas.

Medicare Advantage

Medicare law authorizes Medicare Advantage Special Needs Plans (SNPs) to be excepted from certain broad beneficiary enrollment requirements and limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices and drug formularies to meet the specific needs of those groups. Current law authorized those plans through 2016; MACRA extends that authority for SNPs through 2018.

Therapy Services

Legislation enacted in 1997 created an annual per-Medicare-beneficiary cap of \$1,500 for certain outpatient therapy services. The annual cap applied to physical and speech therapy combined, and separately to occupational therapy. From 1997 through the end of 2005, the caps were not imposed, because Congress enacted a series of laws temporarily suspending the caps.

In 2005, Congress enacted legislation that allowed the caps to go into effect in 2006, but also established an exceptions process whereby Medicare beneficiaries can request and be granted an exception to the caps, and receive an unlimited amount of therapy services to the extent deemed medically necessary by Medicare. The 2005 law authorized the exceptions process for only one year, but Congress has also repeatedly extended the exceptions process.

MACRA extends this exceptions process and directs CMS to utilize manual medical review of exceptions requests on suppliers of therapy services who, among other things, have high denial rates, have a history of aberrant billing or are new enrollees.

Community Health Centers

The ACA provided additional funds to upgrade and enhance facilities and services furnished by community health centers. The ACA provided authority for the supplemental funds and funding through 2015. MACRA extends the authority and funding an additional two years, through 2017, at current funding levels.

Beneficiaries

MACRA makes two changes directly affecting Medicare program beneficiaries as a means of realizing program savings to help offset the cost of the other provisions in the legislation, including the SGR repeal. Generally speaking, a beneficiary’s Medicare premium for Part B and Part D is a percentage of the program cost, and that percentage is determined based on income.

Under MACRA, beginning in 2018, high-income beneficiaries (*i.e.*, those with modified adjusted gross income over \$133,500 for an individual and \$267,000 for a couple) will be required to pay a higher percentage of their premiums. Additionally, for new enrollees only, beginning in 2020, MACRA restricts Medigap plans to

covering costs above the amount of the Part B deductible.

MACRA is as significant for what it does not include as for what it does.

Miscellaneous

MACRA includes dozens of other changes in addition to those listed above, including two more years of funding to support the Children’s Health Insurance Program.

The new law also makes a number of “program integrity” changes, including:

- changes affecting “face-to-face” physician order requirements applicable to suppliers of durable medical equipment;
- a requirement that the Department of Health and Human Services issue a clarification or modification with respect to federal regulations governing the protection of human subjects in research, commonly known as the “Common Rule”;
- a provision that removes from civil monetary penalty risk efforts by providers to reduce or limit services that are not medically necessary; and
- a provision revising the surety bond obligations of home health agencies and durable medical equipment

suppliers seeking to participate in the competitive bidding program.

Analysis

MACRA is as significant for what it does not include as for what it does.

Many providers, especially hospitals and post-acute care providers, feared they would be made to pay a bigger share of the cost of repealing the SGR, and both groups are relieved that the legislation did not include changes to eliminate payment differences across outpatient settings and post-acute care provider types.

Most hospitals also are relieved that the legislation did not advance a new short inpatient stay payment system or further delay ICD-10 implementation.

While MACRA is indeed a major piece of Medicare legislation, perhaps one of the largest to advance since the ACA in 2010, it may not be the only Medicare bill to work its way through Congress in 2015.

Later this year, Congress is expected to craft a new budget for FY 2016, which may require revisiting sequestration and may seek to achieve some measure of deficit reduction.

Moreover, Congress may be forced to contend with the ACA if the U.S. Supreme Court wreaks havoc on the health care law through a decision in *King v. Burwell* that invalidates insurance premium subsidies in states with federal exchanges.

All of these developments could lead to additional Medicare changes, any of which could again put providers and beneficiaries on the defensive.